U.S.Department of Health & Human Services

HRSA

Health Resources & Services Administration

ANNUAL PERFORMANCE PLAN

FY 1999

Index

HEALTH RESOURCES AND SERVICES ADMINISTRATION

ANNUAL PERFORMANCE PLAN: FY 1999
EXECUTIVE SUMMARY

Overview of the Agency

For Americans in need of health care, the Health Resources and Services Administration (HRSA) supports a wide variety of programs that put health care services and professionals where they are least available. Most Americans don't have to think twice; when they are sick, they see a doctor, nurse or other health professional. But many others--50 million or more--face serious barriers to receiving care.

Forty-two million have no health insurance. More than 80 percent of them are working, but without health benefits, and cannot afford the $6,000 each year that it costs to provide basic coverage for a family of four. Others qualify for Medicaid, Medicare or private insurance, but they live in the heart of a city or in the rural heartland and have no doctor, nurse or other primary care provider to call their own. Some have HIV/AIDS or another health condition that makes basic health care more necessary, but less accessible.

HRSA is structured to deal with these problems and to focus on:

Primary Health Care for the Poor, Uninsured and Isolated:

- HRSA supports a network of primary care health centers that deliver primary care--preventing disease and treating illness--in underserved areas. Each year, more than 8 million Americans receive care through HRSA health centers. More than half are members of working families with no health insurance. They pay for services on a sliding scale based on their ability to pay. About 40 percent are Medicare or Medicaid beneficiaries.

Health Care for Americans with Special Health Care Needs:

- A major HRSA focus is on the health of mothers, children and youth, particularly minority, low-income and uninsured individuals and families who face barriers to needed health services, such as prenatal care and immunization. Through the Maternal and Child Health Block Grant, each State assesses the health care needs of its pregnant women, children and adolescents, then develops and implements a plan to meet them.

- Ryan White CARE Act programs are designed to help people with HIV/AIDS live better and longer. Funding provides health and support services for under- or uninsured people with HIV/AIDS. The AIDS Drug Assistance Programs are designed to make available the latest therapeutic approaches to care for those who would not otherwise have access to such care.

Training Health Professionals to Serve the Underserved:

- HRSA supports a variety of community-based training programs to train the next generation of physicians, nurses and other health professionals to work effectively in managed care, to become productive members of health care teams, and to increase the provision of services in underserved areas.

Overall Mission

The overall mission of the Health Resources and Services Administration is to improve the Nation's health by assuring equitable access to comprehensive, quality health care. To assist in that mission, HRSA must:

- Work with States and communities which form the foundation for developing integrated service systems and the appropriate health workforce to help assure access to essential high-quality health care.

- Assure that these systems take into account cultural and linguistic factors, geographic location, and economic circumstances.

- Assist States and communities to identify and address unmet service needs and workforce gaps in the health care system.

- Promote continuous quality improvement in health services delivery and health professions education.

- Support innovative partnerships to promote effective, integrated systems of care for all population groups.

- Promote the recruitment, training and retention of a culturally and linguistically competent and diverse health care workforce.

HRSA has recently completed a strategic planning process which focuses on long term goals, even beyond the normal five year planning cycle. These goals are designed to be end points, and will require intermediate steps along the way, but they do convey the direction in which the agency is headed. That strategic planning effort identified three such long term goals:

Goal #1: Eliminate Barriers to Care - To assure access to comprehensive, timely, culturally competent and appropriate health care services for all underserved, vulnerable and special needs populations.

Goal #2: Eliminate Health Disparities - To eliminate disparities in health status and health outcomes for underserved, vulnerable and special needs populations.

Goal #3: Assure Quality of Care - HRSA will assure quality care is provided to the underserved by fostering a diverse, quality work force and the utilization of emerging technologies.

The HRSA strategic planning effort continues to refine the specific goals and objectives that will be included in a final version of a Strategic Plan.

The Department of Health and Human Services has developed a final Strategic Plan, which was forwarded to the Congress in September, 1997. The overall HRSA directions and program efforts are consistent with and supportive of the Department goals, which include:

- Goal 1: Reduce the major threats to the health and productivity of all Americans.
- Goal 2: Improve the economic and social well-being of individuals, families, and communities in the United States.
- Goal 3: Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.
- Goal 4: Improve the quality of health care and human services.
- Goal 5: Improve public health systems.
- Goal 6: Strengthen the nation's health sciences research enterprise and enhance its productivity.

Need for Linkage to External Resources and Partnerships:

A major source of the Agency's strength is in the linkages and partnerships that have been formed with a variety of Federal and external partners. Collaboration with the several DHHS and other Federal agencies will continue to be a way of doing business. HRSA is forming new linkages with our Federal partners such as:

- Health Care Financing Administration: HRSA and HCFA are jointly implementing the Children's Health Initiative, with particular focus on the new State Children's Health Insurance Program. Additional efforts are aimed at improving data sharing and coordination, particularly with the Medicaid program.
- Centers for Disease Control and Prevention: Partnership efforts are focused on a variety of disease prevention and health promotion activities, including immunization efforts, and with regard to improved data collection and analysis.
- Substance Abuse and Mental Health Services Administration: Particular focus is given to linking primary care services with services related to substance abuse, particularly given the close linkage between substance abuse and high rates of HIV infection.

A major source of the agency's strength is the linkage and partnerships that have been formed with a variety of grantees and external partners, such as:

- State and local governments through such programs as the Maternal and Child Health Block Grant and Ryan White programs.

- Non-profit health organizations such as the Community and Migrant Health Centers.

- Academic institutions, such as the variety of partners working on health professions issues.

- Foundations, such as the Robert Wood Johnson Foundation, the Kellogg Foundation and the Kaiser Family Foundation.

- National associations, such as those representing State and local public health departments and groups of primary care providers.

- Business groups such as the Washington Business Group on Health.

Substantial work has been done toward establishing new working relationships and agreements with such outside organizations. HRSA will continue to need to receive State, local and non-profit input to help assure that programs are designed to meet the needs of the underserved. The agency will need to leverage existing resources, work more creatively with established partners, and plan closely with new partners at all levels to assure the highest degree of coverage possible for the populations-at-need.

HRSA's Primary Operating Units

The primary operating units in HRSA each contribute to this overall mission and major goals and objectives:

The Bureau of Health Professions
Mission: To provide national leadership to assure a health professions workforce that meets the health care needs of the public.

The Bureau of Primary Health Care
Mission: To increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations.

The HIV/AIDS Bureau
Mission: To provide leadership in the delivery of high quality HIV primary care and supporting services for uninsured and underinsured individuals and families affected by HIV/AIDS.

The Maternal and Child Health Bureau
Mission: To work on behalf of America's mothers, children, and families in ways that will assure continued improvement in their health, safety, and well-being.

The Office of Rural Health Policy
Mission: To be the leading Federal proponent for better rural health care services.

The Office of Special Programs
Mission: To ensure access and capacity to scarce resources, such as through organ transplant programs.

Key External Factors That May Affect Plan

The HRSA Performance Plan has been developed during a period of rapid change in health care. Some of the key factors that will affect the agency plan are as follows:

- **Dominance of Managed Care:** As we move into an era where the majority of our Nation is enrolled in managed care plans, cost containment pressures will most likely continue to influence patient access to and the delivery of health care services. To ensure that underserved, vulnerable, and special needs populations (especially those without health care insurance) have continued and increased access to needed services, HRSA must work with its network of providers to gain the capacity to meet new financial and operating requirements needed to sustain the provision of care to these populations in a managed care environment.

- **The Number of Uninsured**: The lack of insurance coverage will continue to be a major influence in the shaping of the Agency's future. The increase in the number of uninsured is not expected to abate for certain segments of the population. As a result, more of the poor will become reliant on health care provided by HRSA-funded providers.

- **Aging Population:** Worldwide, we will be experiencing the effects of the profound aging of the overall population, a foretaste of the coming needs of the aging "baby boom" generation. Mortality rates have decreased, increasing the probability of living into one's eighties. The magnitude of this demographic change will require new and different approaches to the organization and delivery of care.

- **Changing Health Care Workforce:** The current paradigm for the health care workforce appears to be shifting and will continue to change over the next few years. The demand for an inter-disciplinary trained health professions workforce along with the emergence of new types of health care workers (e.g., wellness/health coaches and visiting home health care teams with cross-disciplinary training) will require new approaches to training health care providers and to the delivery of health care.

- **Technological Advances:** Rapid developments in telecommunications, including the transmission of medical data, training and interpersonal communication is revolutionizing the health industry.

Approach to the Performance Plan

HRSA has made a strong effort to build a performance management approach into the way it conducts its business. The agency structured the development of its internal strategic planning process to be consistent with the requirements of the Government Performance and Results Act (GPRA). The goals developed in the process have guided the development of the Annual Performance Plan for FY 1999.

HRSA began the performance measurement effort with an assessment of all programs and their readiness for measuring performance, beginning with the GPRA requirements as the basis for the review. The agency, using each major program budget line:

- Identified both strengths and weaknesses in terms of ability to measure performance.
- Assessed the current availability of indicators and data that can be used to ensure effective management of resources.
- Identified key areas where developmental activities are needed and have channeled agency resources to these areas.

The agency outlined the central assessment question of organizational performance:

> *Can this organization, with a given set of resources, through a series of actions and decisions, produce outputs that have the desired effects and outcomes to benefit those it serves?*

The Essential Performance Question

Can this organization	...with these resources...	...through these actions, processes and decisions...	...yielding these products...	...have these effects...	...for these people?
HHS HRSA 4 Bureaus Programs Activi-ties	Legislative Authority Budget Authority Staff Equipment/ Supplies Information and Data Systems	Data Collection Research/ Analysis Problem/Needs Assessment Methods Development Standard Setting Grant-making Contract Awards Program Coordination	Service Delivery Training Technical Assistance Demonstrations /Experiments Knowledge/ Awareness Skill/Capacity Guidelines	Access to Care Improved Utiliza-tion Improved Quality Lower Mortality/ Morbidity Increased Life Expectancy Improved Health Status	Vulnerable Populations Medically Underserved Persons with HIV/AIDS Children with Special Health Care Needs Persons in Border Communities
Organization Level	Input	Process	Output	Outcome	Customers

Technical assistance has been provided to each of the operating components to enhance ability to define performance goals and measures. Pilot performance plans were developed for five major program activities during preparation of the FY 1998 budget. For the FY 1999 budget, Annual Performance Plans are included for all major program activities.

The plan contains a mix of process, output and outcome indicators. Basic distinctions among these are as follows:

- **Process**: A program's internal activities (e.g., training approach used).
- **Output:** A program's direct products or services (e.g., number of people provided health services, number of people trained), including product/service characteristics such as timeliness, quality and efficiency.
- **Outcome**: Results of program output (e.g., changes in health status, mortality or morbidity).

Although the ultimate target is to produce outcome-oriented performance goals, since these are the desired indicators of program results, it should be recognized that output and process measures are also important and frequently the most realistic indicators of performance. They are often the only indicators currently available on an annual basis and reflect the level of control an agency can bring to bear through particular programs. HRSA will work to increase the use of outcome measures and to demonstrate the relationship between its process measures and the desired outcomes.

Throughout the HRSA plan, there are performance goals of each of these types. Within the Maternal and Child Health program, for example, outcome measures are emphasized. Data will be collected on core performance measures from all States, including tracking of the infant mortality rate, and the disparity between the black and white infant mortality rate. Within the Bureau of Health Professions, there is currently a strong reliance on output measures, such as number of students trained by type. The Bureau has developed a Comprehensive Performance Monitoring System which will begin to capture common activities across programs and measure the aggregate effects of grantee achievements. An example of such a cross-cutting goal is to increase the number of graduates and/or program completers who enter practice in underserved areas.

Data Issues

There are numerous concerns about the availability and cost of data to measure performance and results. Data systems have often been initiated to measure the results of individual programs. Many programs target the same populations, so there is potential for individual programs trying to obtain different information, in different formats and at different times, from the same source, thereby increasing the reporting burden at the grantee level.

It is clear that additional effort is needed to move toward increased use of common, structured and standardized data strategies to carry out an effective system of performance measurement. A good deal of work has already been initiated in this area. The Bureau of Primary Health Care is implementing a Uniform Data System for its primary care health centers. This provides extensive demographic information, utilization, revenues and costs for user populations annually. The Maternal and Child Health Bureau has worked with the states to reach agreement on a set of core, or benchmark, performance measures to be utilized by every state, so as to be able to assess progress against the baselines for these measures in each state. As noted, the Bureau of Health Professions is implementing its Comprehensive Performance Monitoring System.

Another data issue is the competing need to collect essential performance measurement information, while at the same time attempting to meet the requirements of the Paperwork Reduction Act which aims to reduce the reporting burden associated with participation in Federal programs. These competing needs are at times difficult to resolve.

Because HRSA programs are carried out by grantees at the state and local level who often use subgrantees or contractors to perform the work, the system is

not structured to produce a routine flow of data on grantee performance and outputs. HRSA is working to establish useful and efficient systems for gathering performance and accountability information.

This variety of data issues will continue to be addressed as we proceed with the development of our performance measurement strategy.

Performance Measures

HRSA has made an effort to link its performance goals and measures to its three primary goals:

- **Eliminate Barriers to Care:** Goals and measures relate to assuring that HRSA programs reach more of the neediest populations, and that our programs work with state and local partners to assure that safety net providers are available to fill unmet needs.

- **Eliminate Health Disparities**: Goals and measures focus on health status measures and assuring that improvement in health status continues until disparities are eliminated.

- **Assure Quality of Care:** These goals and measures focus on improving the content of care, on fostering a diverse, quality workforce, and on expanded use of emerging technologies.

The HIV/AIDS Bureau, for example, has proposed a performance goal that is targeted at both eliminating barriers to care and assuring quality of care:

> *Increase the number of ADAP utilizers receiving appropriate anti-retroviral therapy (consistent with current clinical guidelines) through State AIDS Drug Assistance Programs (ADAP) during at least one month of the year to a projected level of 57,500 people in 1999.*

The HIV/AIDS Bureau, in addition to targeting strategic planning goals, has focused on three major targets:

- Client - To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

- Provider - To assure improved delivery of services and increased access to services as a result of the CARE Act.

- Systems - To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

Performance goals aimed at eliminating disparities include those developed by the primary care programs, such as:

> *Demonstrate the ability of Health Centers to reduce or eliminate health status gaps affecting minority and low income populations, including those conditions selected for the President’s race initiative:*

Cardiovascular disease, diabetes, cancer, HIV/AIDS, immunizable disease and infant mortality.

Other primary care performance goals emphasize eliminating barriers to care, by focusing on the number of uninsured and underserved people served, as well as the proportion of services delivered to low income individuals.

The Maternal and Child Health Program has identified a core and an outcome set of measures that states will start reporting on in 1998. The state core and outcome measures have been developed during a process which involved states, concerned public interest groups, and experts in public health. The range of agreed upon measures covers all three major HRSA goals.

Eliminating barriers to care, for example, is reflected in:

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Assuring quality of care is reflected in:

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Within the Bureau of Health Professions, the effort is being made to move beyond strict output measures to begin to measure whether students actually begin to practice in underserved areas and in primary care specialties. For example:

Increase the percentage of graduates of medical school practicing in primary care from 35 percent to 40 percent.

Number of family medicine graduates and/or program completers who enter practice in underserved areas.

It is clear that the development of performance goals and indicators is an evolving process that will require a good deal of work and resources. HRSA has devoted considerable effort to this initial plan, and expects to see significant improvements as additional experience is gained.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

AGGREGATION OF PROGRAM ACTIVITIES IN ANNUAL PERFORMANCE PLANS

Primary Care

Health Centers/National Health Service Corps
Black Lung Clinics
National Hansen's Disease Program Cluster
Federal Occupational Health

HIV/AIDS Programs

AIDS: HIV Emergency Relief Grants (Part A)
AIDS: HIV Care Grants to States (Part B)
AIDS: HIV Early Intervention Services (Part C)
AIDS: HIV Pediatric Grants
AIDS: Special Projects of National Significance
AIDS Education and Training Centers
AIDS: Dental Services Program

Maternal and Child Health

Title V - Maternal and Child Health Block Grant
Emergency Medical Services for Children
Healthy Start
Traumatic Brain Injury Program
Title V - Abstinence Education Program

Health Professions

Health Professions Training for Diversity:
- Centers of Excellence in Minority Health
- Health Careers Opportunity Program
- Faculty Loan Repayment Program/Minority Faculty Fellowships

Student Assistance:
- Scholarships for Disadvantaged Students
- Exceptional Financial Need Scholarships
- Financial Assistance for Disadvantaged Health Professions Students
- Loans for Disadvantaged Students

Interdisciplinary, Community-Based Training:
- Area Health Education Centers
- Health Education and Training Centers
- Rural Health Interdisciplinary Training
- Geriatric Programs
- Allied Health Special Projects
- Chiropractic Demonstration Projects
- Podiatric Primary Care Residency Training

Primary Care Medicine and Dentistry:
- Family Medicine Training
- General Internal Medicine/General Pediatrics Training
- Physician Assistant Training
- General Dentistry Training

Public Health Workforce Development:
- Public Health and Preventive Medicine
- Health Administration

Workforce Information and Analysis

Nursing Education and Practice:
- Nursing Special Projects
- Advanced Nurse Education
- Nurse Practitioner and Nurse Midwives
- Professional Nurse Traineeships
- Nurse Anesthetist Training
- Nursing Education Opportunities - Disadvantaged Backgrounds

Health Education and Assistance Loans (HEAL) Program

National Practitioner Data Bank

Vaccine Injury Compensation Program

Office of Special Programs

Organ Procurement and Transplantation
National Bone Marrow Donor Program

Rural Health

Rural Health Outreach
Rural Health Policy Development
State Offices of Rural Health

PRIMARY CARE

Annual Performance Plan: FY 1999 Budget

Mission and Overview:

The mission of the Bureau of Primary Health Care (BPHC) is to increase access to primary and preventive care and to improve the health status of underserved and vulnerable populations. BPHC seeks to meet its mission through the development and support of systems and providers of high quality, community based, culturally competent care. Targeted populations include the uninsured, underinsured, underserved, low income, women and children, homeless persons, migrant farm workers and people in frontier and rural areas. Through its programs, BPHC assists communities in addressing the needs of these populations, who are particularly at risk for poor health outcomes, and builds broader primary care capacity through partnerships with States and localities. Over 10 million of the Nation's neediest people receive care through BPHC programs emphasizing prevention, early detection and timely intervention in more than 3500 communities.

Programs of the BPHC include:

- -- Health Centers and the National Health Service Corps
- -- Black Lung Clinics
- -- The National Hansen's Disease Program Cluster
- -- The Federal Occupational Health Program

Funding criteria and service area requirements for BPHC programs result in a strong focus on low income individuals and people of color. Of those served, 65 percent have incomes under the Federal poverty level, and 85 percent below 200 percent of poverty, while over 60 percent are racial/ethnic minorities. Over 40 percent of patients are uninsured, compared with 16 percent in the general population.

Because of its concentration on population groups who usually experience the greatest disparities in access and health status, BPHC is able to measure its impact on reducing or eliminating these disparities. In order to further the measurement of outcomes, BPHC held a consensus conference of experts from NIH, CDC and the health services research community to identify gaps in health status for low income and minority populations amenable to primary care. Those knowledgeable about such conditions as cardiovascular disease, diabetes, cancer, immunization, infant mortality and HIV/AIDS assisted in developing a research and evaluation agenda currently being implemented. The results of these studies are incorporated into the Bureaus's performance measures.

In addition, BPHC has made a major investment in databases and surveys to measure impact on health disparities. These include the Uniform Data System, which provides extensive demographic information, utilization, revenues and costs for user populations annually, and surveys of program users and visits adapted from the National Health Interview Survey and the National Hospital Ambulatory Medical Care Survey, to compare access, diagnoses, services,

continuity, satisfaction and outcomes with the general population and Healthy People 2000 and 2010 objectives.

Thus far, the evidence is quite positive that BPHC's programs improve access and reduce disparities for the people they serve. BPHC performance goals fall into three areas corresponding to the HRSA goals:

1. Eliminating Health Disparities: These goals deal with program outcomes in terms of health status measures--expanding the criteria currently in use and assuring that improvement continues until disparities are eliminated.

2. Eliminating Barriers to Care: These goals relate to assuring that our programs continue to reach more of the neediest populations, survive in the current market-based environment, and bring the advantages of positive outcomes to additional people.

3. Assuring Quality of Care: These goals relate to the content of care and the adherence to industry standards at individual service sites.

Annual Performance Plan: FY 1999 Budget

Program Activity: **Health Centers/National Health Service Corps**

Description of Program Activity:

Health Centers and the National Health Service Corps form a cost effective, integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, public housing and U.S./Mexico border residents in approximately 3,072 communities across the country and will serve 10.35 million persons in FY 1998 who would otherwise lack access to a primary care providers. This community-based network delivers preventive and primary care services for the neediest, poorest and sickest patients in rural and inner city areas, through a Federal, State and community partnership approach. The high quality primary health care received in these programs reduces hospitalization and emergency room use, reduces annual Medicaid costs, and helps prevent more expensive chronic disease and disability.

As described more fully in the budget narrative, this set of programs addresses the major problems that exist with the health care system:

- Approximately 42 million people are uninsured. Of these, approximately 4 million are served by the primary care network.

- From 1990 to 1996, the number of uninsured patients at Health Centers increased by 46 percent compared to a nationwide increase of 20.2 percent.

- When the need for primary care is examined in geographically defined service areas, it is calculated that 43 million persons lack access to a primary care provider. Some 10.4 million are served by these primary care programs.

- Disparities in health status and access for low income and minority populations persist. Of those served by these primary care programs, 85 percent have incomes below 200 percent of poverty and over 60 percent are racial/ethnic minorities.

Health Centers and the NHSC have developed an Access Plan to meet current and future demands of the growing uninsured population, survive in an increasingly competitive system and address remaining needs of underserved areas and populations. The Access Plan focuses on three areas:

- the development of new sites in areas that have not previously had health centers/NHSC activity

- the expansion of existing Health Centers to serve even greater numbers of patients in their areas

- the specific expansion of Health Center/NHSC health care capacity to uninsured and underserved children (in support of the Secretary’s Children’s Health Initiative) and U.S./Mexico border residents.

Annual Performance Goals and Performance Indicators:

As indicated above, BPHC's performance goals for Consolidated Health Centers and the National Health Service Corps relate to the three HRSA goals: Eliminating Health Disparities, Eliminating Barriers to Care, and Assuring Quality. They are geared to continuing reduction and eventual elimination of racial and income disparities, and to extending the benefits of current programs more broadly.

Performance Goals:

A. Demonstrate the ability of Health Centers to reduce hospital utilization and costs for major conditions sensitive to ambulatory care interventions.

   Indicator: Utilization of hospital care and costs for Health Center users, by demographic characteristic and diagnosis, compared with similar populations.

B. Demonstrate the ability of Health Centers to reduce or eliminate health status gaps affecting minority and low income populations, including those conditions selected for the President's race initiative: Cardiovascular disease, diabetes, cancer, HIV/AIDS, immunizable disease and infant mortality.

   Indicator: Control of risk factors and reduced morbidity from these conditions for Health Center users compared with similar populations.

C. Serve an additional 150,000 uninsured and underserved persons through the Health Centers and the NHSC, with particular emphasis on areas with high proportions of uninsured children in order to help implement the Administration's Child Health Initiative. (Baseline: 10.4 million served in 1998.

   Indicators:
   - Total number of clients in unserved areas served.
   - Number of additional uninsured and underserved persons served in FY 1999.

D. Target primary care services to low income individuals, so as to assure at least current levels of coverage. (Baseline for FY 1998: 85 percent of patients below 200 percent of poverty)

   Indicator:
   - Proportion of Health Center patients below 200 percent of poverty

E. Assure access to services for minority patients. (Baseline for FY98: Proportion of population served includes 27 percent African-American; 31 percent Hispanic; and 3 percent Asian/Pacific Islander).

   Indicator:
   Proportion of Health Center clientele that are underserved minorities.

F. Increase by 20 the number of new Health Center sites. (Baseline for FY98: 3,072 sites).

Indicators:
- Total number of sites providing access to services
- Number of additional new sites

G. Create an additional 900 jobs in medically underserved communities. (Baseline: This is part of the Administration's initiative on Welfare-to-Work. It is expected that approximately 10 percent of these new jobs will be entry level positions).

Indicator:
Number of additional jobs created in medically underserved communities

H. Health centers will have formed managed care networks in 70 percent of the states with high public managed care penetration.

Baseline: Initially the focus will be on health centers in states with statewide Medicaid managed care waivers, 50 percent of which currently have health center managed care networks. The importance of this distinction may change over time, in which case HRSA intends to adjust the numerator and denominator accordingly.

Indicator:
The proportion of states with high public managed care penetration that have Health Center managed care networks.

I. Assure that all Health Centers competing for grant funds have undergone quality reviews either by internal or external, nationally recognized processes reflecting industry standards.

Indicator:
Percent of Health Centers competing for funds that have undergone quality reviews.

J. Support scholarships and Federal loan repayment agreements, so as to maintain a field strength of approximately 2,200. Baseline for FY 1998: 375 NHSC scholarships and 465 Federal loan repayment agreements, with a field strength of 2,278 at the end of FY 1997.

Indicator:
Total size of NHSC field strength.

Link to Strategic Goals and Objectives:

The BPHC Health Centers and NHSC Performance Goals are complementary to the following HRSA Strategic Goals:

1. Eliminating Health Disparities
2. Eliminating Barriers to Care
3. Assuring Quality

They are also supportive of the goals in the Department Strategic Plan. Particular linkage is provided in Goal 3: Improve access to health services and ensure the integrity of the Nation’s health entitlement and safety net programs. The Primary Care programs are an essential component of Strategic Objective 3.2: Increase the availability of Primary Health Care Services.

The Health Centers and NHSC Performance Goals are also supportive of the following Secretary's Initiatives:

- Improve health care quality
- Children's health care initiative
- Moving people from welfare to work

Data Collection and Validation:

A. One percent evaluation studies.

B. Consensus conference on health status gaps and evaluation studies that will address impact on gaps.

C. Grant and Uniform Data System (UDS) annual reporting system which is validated by periodic on-site review.

D. Grant and Uniform Data System (UDS) annual reporting system which is validated by periodic on-site review.

E. Grant and Uniform Data System (UDS) annual reporting system which is validated by periodic on-site review.

F. Grant and UDS annual reporting system which is validated by periodic on-site review.

G. Grant and UDS annual reporting system which is validated by periodic on-site review.

H. Grant records and HCFA data on waivers.

I. Contract deliverables and PCER records.

J. NHSC Data Reports

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President’s Budget
$941,410	$15,000	$956,410

Annual Performance Plan: FY 1999 Budget

Program Activity: Black Lung Clinics

Description of Program Activity: The Black Lung program provides funding to public and private entities for the operation of clinics which provide diagnosis, treatment and rehabilitation of active and retired coal miners with respiratory and pulmonary impairments. In addition to treatment of Black Lung disease and directly related conditions, coverage includes prescription drugs, office visits, hospitalizations, and, with specific approval, durable medical equipment, outpatient pulmonary rehabilitation therapy, and home nursing visits.

Since 1984, Black Lung beneficiaries have steadily declined. In FY 1984, approximately 100,000 primary beneficiaries filed almost 164,000 claims. It is projected that in FY 1998, approximately 70,000 primary beneficiaries will file about 140,000 claims. Over time the number of beneficiaries may continue to decline.

Annual Performance Goals and Performance Indicators:
Performance Goal:

A. Serve approximately 52,350 users, including provision of medical and non-medical services, through 14 Black Lung Clinic grantees which maintain Black Lung Clinic sites.

Indicator:
Number of individuals provided medical and non-medical services.

Link to Strategic Goals and Objectives:

The BPHC Black Lung Clinic Performance Goal is supportive of the following HRSA Strategic Goals:

- Eliminating Barriers to Care
- Assuring Quality of Care

It is also supportive of Department Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs.

Data Collection and Validation:

A. Grantee annual reports.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$5,000	---	$5,000

Annual Performance Plan: FY 1999 Budget

Program Activity: National Hansen's Disease Program Activities

Description of Program Activity: The Hansen's Disease program cluster consists of the National Hansen's Disease program at Carville, Louisiana and other outpatient clinic locations in the continental United States and a direct payment to the State of Hawaii Department of Health. These activities provide or support treatment of Hansen's disease. The program also includes a research component at Louisiana State University.

HRSA will implement legislation that will relocate the National Hansen's Disease program from Carville, LA to Baton Rouge, and transfer ownership of the Carville facility to the State of Louisiana.

Annual Performance Goals and Performance Indicators:

Performance Goals:

A. Depending on the state of transfer, continue to provide residential care for the current 125 HD residential patients (FY 1999 estimate: 110 patients)at Carville in the most cost effective manner possible.

   Indicator:
   Extent to which residential care continues to be provided for the remaining residents.

B. Depending on the state of transfer, continue to provide clinical care for an average daily census of 15 HD patients who require specialized services at Carville.

   Indicator:
   Extent to which clinical care is provided for those requiring specialized services.

C. Continue to provide outpatient care for 3,000 HD patients across the country.

   Indicator:
   Extent to which outpatient care is provided for HD patients

Link to Strategic Goals and Objectives:
These goals are supportive of the HRSA Strategic Goals to Eliminate Barriers to Care and Assuring Quality of Care.

The program is also supportive of Department Goal 3 on improving access to health services, particularly Strategic Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation

Data Sources(s) for Performance Goals:

A. Data provided by program managers.

B. Data provided by program managers.

C. Data provided by program managers.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$21,639	-$2,324	$19,315

(This includes a payment to the State of Hawaii for support of treatment of Hansen's Disease patients at a level of $2,045,000 in both FY 1998 and 1999. It also includes a building and facilities account at a level of $2,500,000 in FY 1998 and $250,000 in FY 1999).

Annual Performance Plan: FY 1999 Budget

Program Activity: Federal Occupational Health

Description of Program Activity: The Federal Occupational Health (FOH) program provides occupational health services and consultation to federal employees. The Public Health Services Act authorizes the heads of federal agencies to provide occupational health services to their employees. About 160 Departments and agencies elect to do so by entering into agreements with the Division of Federal Occupational Health (FOH) , which is a part of the Department of Health and Human Services' Health Resources and Services Administration. The FOH program provides occupational health consultation and services to other federal agencies under Government Management and Reform Act inter-agency agreements. It's over-all objective is to improve the health and safety of the federal workforce. The mission statement for FOH is: *"to become the benchmark for occupational health in the nation."* FOH's vision is:

> "to be the provider of high-quality, cost-effective consultation and services that constitute a comprehensive approach, with a public health perspective, to improving the health and safety of the work force, through clinical, environmental, educational, and risk-based prevention programs."

In FY 1997 FOH carried out 4,000 inter-agency agreements with 160 client federal agencies, who reimbursed FOH $84 million. Specifically:

- $19 million for basic clinical occupational health consultation and services for about 10 percent of the federal workforce

- $20 million for specialized clinical occupational health consultation and services. This included consultations with individual management officials and groups of managers, plus direct clinical services to individual employees and groups of employees.

- $8 million for environmental health services that benefit undefined numbers of employees in worksites where environmental problem are prevented or remediated

- $37 million for employee assistance programs available to over 1 million employees

The employee populations cited are not mutually exclusive. All told, FOH estimates that its programs directly benefit 1.3 million of the total 2.8 million federal employees.

FOH provides clinical services to employees and consultation to management under two different types of inter-agency agreements: (1) walk-in service at permanent centers offering basic, comprehensive, nationally-standardized clinical services; and (2) specialized, on-demand-only clinical interventions wherever needed to help agency managers meet their specific occupational health responsibilities arising out of legislative and regulatory requirements or agency initiatives.

Environmental health services enable customer federal agencies to comply with legislative and regulatory requirements for job safety/health/and environmental matters. Methods include environmental and worker exposure monitoring, hazardous waste/materials management, safety audits, and training of employees and managers. These services meet the agency's need to create a safe workplace, and to identify, evaluate and control occupational health and environmental hazards to health. They protect employees, visitors, the general public, and the man-made and natural environment. They aid in the reduction of both work-related and non-work-related injury and illness.

Employee Assistance Programs provide consultation to supervisors regarding employee services (assessment of employee emotional, substance abuse, or situational problems that may interfere with job performance) and short term counseling for employees. Employees are more likely to be helped early in the course of an illness when confrontation and resolution occurs in the job setting, and when the source of help is close at hand and easy to access. This reduces the cost of treatment (including Federal benefits costs) and returns the employee to a more productive status sooner, thus minimizing productivity losses. Critical incident stress debriefing benefits groups of otherwise well employees who have just suffered trauma on the job. It helps them understand normal reactions to abnormal situations, and offers individual personal assistance when necessary.

Annual Performance Goals and Performance Indicators:

Performance Goals:

A. Improve total customer satisfaction

   Indicator: Percent of customer federal agencies in stratified sample who report that they are either generally or completely satisfied with FOH services and consultation

   Baseline: FY 1997 survey results - Clinical 78 percent Environmental 88 percent EAP 68 percent.

B. Provide lowest possible per-capita charges for services consistent with high value to the customer.

   Indicator: Dollar amount of per-capita charges

   Baseline: FY 1997 charges: Clinical $85; EAP $23

C. Timely responses to federal workplace personal health emergencies and incidents of violence.

   Indicator: Number of complaints that response times guarantees in interagency agreement with the customer agency were not met.

   Baseline: Number of complaints in FY 1997 - One incident

FOH has also committed itself (in its application to the Office of Management and Budget for designation as a GMRA franchise fund pilot activity) to using an additional six performance goals if suitable outcome data can be obtained from customer agencies. Those goals are:

D. Increase federal workforce productivity by reducing use of sick leave
E. Reduce cost and liability through environmental site assessments
F. Reduce the amount of workers compensation payments
G. Reduce backlogs of unresolved disability cases
H. Reduce the number and severity of job-site injuries
I. Give medical surveillance exams to all employees whose occupations warrant

Link to Strategic Goals and Objectives:

These goals are supportive of the HRSA strategic goal to assure quality of care.

The program is also supportive of goals in the Department Strategic Plan, particularly Goal 4: Improve the quality of health care and human services.

Data Collection and Validation:

Customer satisfaction is measured by a survey mechanism. Per capita charges are computed by dividing anticipated costs by population to be served. On responses to emergencies, FOH quality assurance staff records and follows up on all complaints from customers that emergency incidents were not handled properly, as defined in the provisions in the interagency agreements. For the remaining performance goals, data collection approaches are still under development.

Funding Levels Associated with this Program Effort

(Dollars in Thousands)

FY 1998 Operating Level (est.)	FY 1999 Increment	FY 1999 Operating Level (est.)
$110,000	$11,000	$121,000

HIV/AIDS PROGRAMS

Annual Performance Plan: FY 1999 Budget

Mission and Overview

The programs of the HRSA HIV/AIDS Bureau (H/AB) are focused on improving the quality and availability of care for people living with HIV/AIDS and their families. The principal objectives of the HRSA HIV/AIDS programs are to provide and administer programs that include an emphasis on: primary health care, support services, prevention initiatives, and training for health care professionals. The Bureau's mission underscores the need to serve persons living with HIV/AIDS by developing and sustaining systems of health care responsive to local and community needs. Data collection to assess the effectiveness of these programs remains both a priority and a particular challenge due to the sensitive nature of the information involved.

Between 600,000 and 900,000 people are estimated to be living with HIV in the United States. Assuming a mid-point of 750,000, approximately 200,000 are estimated to be living with AIDS. The target populations for the HRSA HIV/AIDS (Ryan White CARE Act) Programs are those individuals with HIV who are uninsured, or under-insured, and who have low incomes. Using data from the 1991-1992 AIDS Cost and Services Utilization Survey (ACSUS), of the estimated 750,000 individuals with HIV, approximately 30 percent (225,000 individuals) are uninsured and 20 to 30 percent had incomes of less than $1,150 during the month preceding the survey. The number of underinsured is unknown, but at least 31 percent of people with HIV receive public insurance. These percentages increase as individuals move from HIV to AIDS and as newly HIV-infected individuals come increasingly from poorer populations. An analysis of the 69,151 cases of AIDS reported to CDC in 1996 indicates that AIDS is occurring increasingly among women, drug users, and minorities, in rural areas, and specific regions of the U.S.

The HRSA HIV/AIDS programs are authorized by the Ryan White CARE Act, as amended, under Title XXVI of the Public Health Service Act. The programs include:

- **Part A (Title I):** HIV/AIDS Emergency Relief grants for eligible metropolitan areas (EMAs);
- **Part B (Title II):** HIV/AIDS Care grants to States;
- **Part C (Title III):** HIV/AIDS Early Intervention Services provided at community-based health care centers;
- **Part D (Title IV):** Coordinated HIV/AIDS services and access to research for children, youth, women and families;

- **Part F:** Special Projects of National Significance (research and demonstration projects on innovative systems of care);

  AIDS Education and Training Centers (for the training of health professionals on HIV/AIDS treatment issues);

  HIV/AIDS Dental Reimbursement (funding for dental school post-doctoral programs to provide uncompensated dental care to persons living with HIV/AIDS).

(Note: Part E has never been funded)

Taken together these programs reflect the Bureau's major strategic goals of: assuring early and equitable access to life-enhancing care, assuring that all appropriate health care providers utilize current standards for the clinical care of persons living with HIV/AIDS, and establishing integrated systems of HIV care and support services in all disproportionately affected areas of the Nation.

It is important to note that HRSA's HIV/AIDS programs are part of a larger picture combining the resources of federal, state and local jurisdictions in a unified effort to provide high quality health care services to the broadest number of persons. To the extent that the performance measures described below have an impact on client/patient outcomes and health status, that impact occurs within the broader context of multi-level participation (federal/state/local). Through needs assessments and involvement of interested community members, state and local planning councils ultimately make the decision as to the allocation of resources to providers within their jurisdictions (as in the Title I and II Programs). The combined intent of the HRSA HIV/AIDS programs is to assure that the appropriate infrastructure, planning processes, health care services, and quality assurance mechanisms are in place to reach those most in need of these programs. Included in this assurance function are: case management and enabling services that increase access and assure continuity of primary care services for persons living with HIV/AIDS.

In managing the functions of the HRSA HIV/AIDS programs, the Bureau works closely with partners from within the Department, such as CDC, SAMHSA and HCFA. Our Bureau Strategic Plan also emphasizes key areas for continued collaboration with national organizations representing both health care professionals and consumers involved in HIV/AIDS service delivery. Crucial to the success of the HIV/AIDS programs is the involvement of state public health systems and local-level service delivery organizations.

Performance indicators have been identified for each of the HRSA HIV/AIDS programs. The indicators are focused around three major results-oriented performance goals:

Client: To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

Provider: To assure improved delivery of services and increased access to services as a result of the CARE Act.

Systems: To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

Based on the three broad measures of program performance that have been developed (client outcomes, provider input, and system capacity), each program has chosen specific indicators for each broad measure of performance, based in large part on that program's current data collection system.

The Bureau's performance measures reflect the Department's strategic goals to improve access to, and the effectiveness of, health care services for persons with specific health care needs.

The performance measures or indicators are based primarily (but not exclusively) on program data systems developed between 1991 and 1995. Each of the seven HRSA HIV/AIDS Programs developed, obtained OMB clearance, and implemented client and service reporting systems. In the process of developing these data systems, the programs consulted with grantees on the questions to be answered by data elements and the elements to be collected. While some data collection elements differ among the programs, all of the programs collect aggregate data that address access to, and utilization of, services or training. Each program also collects grantee-specific data on unmet need.

The HIV/AIDS Bureau's efforts at measuring performance will evolve over time. Future activities will include: (1) re-evaluation of program data systems in light of program consolidation and gaps in performance measurement (an interactive process will be used in working with grantees to reach agreement on final performance measures and implications for changing data systems); and 2) discussions with CDC on revisions to their systems for HIV surveillance that will provide additional data for HRSA's performance measurement systems. At this time the Bureau is consolidating its data collection responsibilities within one office and looking closely at issues of standard nomenclature and reporting format.

Goals and Measures Related to Combination Drug Therapy

For future iterations of performance measurement, the Agency is considering ways to confidently measure not only who is served by the Ryan White CARE Act Drug Assistance Program, but also who may need those services but not receive them. Measuring unmet need for the AIDS Drug Assistance Program (ADAP) is problematic from a data collection and methodological standpoint, as well as the factors involved in provider decision making on eligibility. Decisions by practitioners are individualized to patient circumstances. Providers need to assess the individual patient's ability to benefit from, and remain compliant with, complex drug treatment protocols involving medications with potentially severe side effects.

Because eligibility for public support -- both Medicaid and ADAP -- is state determined, it is difficult to determine how many individuals throughout the United States will need public financial support to access combination therapy and to project need. Also, the exact number of individuals living with HIV is unavailable due to limitations in nationwide reporting. Utilizing waiting lists as a measure of program performance (or as a measure of unmet need) would provide an unrealistic impression since some states do not allow waiting lists. Contributing to the difficulty in estimating need for ADAP services are the unknown number of HIV-infected individuals who are receiving some pharmaceuticals through Medicaid or private insurance but who still may require ADAP coverage for prescribed medications. Neither HCFA, CDC, nor HRSA have the resources to undertake state-by-state monitoring of the frequently changing state coverage policies, the number of HIV positive individuals needing medications who are enrolled in ADAP and Medicaid, and the number of HIV positive individuals living in each state who are either uninsured or who have private coverage but are underinsured. The HIV/AIDS Bureau will continue to explore options to evaluate unmet need for ADAP services through current data collection efforts and future planning for new data collection activities. HRSA will also study what measures of States' and other partners' efforts on behalf of people with HIV/AIDS it should use and how these efforts contribute to the well being of people with HIV/AIDS.

Annual Performance Plan: FY 1999 Budget

Program Activity: AIDS: HIV EMERGENCY RELIEF GRANTS (Part A)

Description of Program Activity:

Title I, the HIV Emergency Relief Grant Program, provides funds to cities and metropolitan areas that are disproportionately affected by the HIV epidemic. There are two types of Title I grants; formula and supplemental. The grantee is normally the city, but may be the county which provides the largest proportion of services to people with AIDS in the metropolitan area.

Formula Grants

Cities are eligible for Title I formula grants if they have reported a cumulative total of more than 2,000 cases of AIDS (confirmed by the CDC) for the previous five years, and there is a population of at least 500,000 individuals, or, if they have received an award prior to fiscal year 1997. Grants are used for community-based outpatient health and support services for low-income persons living with AIDS/HIV, including comprehensive medical care, prescription drugs, counseling, transportation, meals-on-wheels programs, home care and hospice care. Title I grants may also be used to provide in-patient case management for AIDS/HIV patients to prevent unnecessary hospitalization or to expedite hospital discharge.

Supplemental Grants

All cities that receive Title I formula grants are eligible to compete for Title I supplemental grants, which are awarded later in the fiscal year to cities demonstrating additional critical needs. Half of each year's Title I appropriation is reserved for formula grants; the other half is for supplemental grants based on demonstrated needs.

Annual Performance Goals and Performance Indicators:

Performance Goals:

Client-oriented Goal: To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

A. Increase the total number of unduplicated clients served from an estimated 384,900 in 1996 to a projected 413,700 in 1999, a 7.5 percent increase.

   Indicator:
   Number of clients served under Title I Program (NOTE: numbers related to this performance goal are estimated unduplicated within Title I; the extent of duplication with Title II or other CARE Act Titles is not known).

Provider-oriented Goals: To assure improved delivery of services and increased access to services as a result of the CARE Act.

B. Increase the number of visits for medical care from an estimated 819,600 in 1996 to a projected 880,800 in 1999, a 7.5 percent increase.

Indicator:
Number of visits for medical care

C. Increase the number of visits for dental care services from an estimated 117,500 in 1996 to a projected 125,700 in 1999, a 6.9 percent increase.

Indicator:
Number of visits for dental care services.

System-oriented Goal: To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

D. Serve women and people of color in Title I funded programs in proportions that exceed their representation in overall AIDS seroprevalence by a minimum five percentage points (e.g., if 15 percent of overall AIDS cases are among women, serve 20 percent women in Title I programs).

Indicators:
Number and proportion of women and people of color served in Title I funded programs; number and proportion of women and people of color of the total population who are Seropositive.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

One of the draft strategic objectives is that:

- By 2003, HRSA will assure that HIV-associated morbidity will be decreased by 50 percent.

This program is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation’s health entitlement and safety net programs; Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation: data for performance goals A-D are obtained from the following sources:

- Annual Administrative Reports
- Grant Applications
- Grantees' Needs Assessments

1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Levels Associated with this Program Effort:

Authorizing Legislation: Sections 2601-2607 of the Public Health Service Act.

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$464,800	$25,000	$489,800

Annual Performance Plan: FY 1999 Budget

Program Activity: AIDS: HIV CARE GRANTS to States (Part B)

Description of Program Activity:

Title II of the Act provides formula grants to States, U.S. Territories, the District of Columbia and Puerto Rico to provide health care and support services for people with AIDS and HIV infection. Grants are awarded based on: (a) average per capita income of State to U.S. population; and (b) the number of diagnosed AIDS cases reported to, and confirmed by, the U.S. Centers for Disease Control and Prevention for the two federal fiscal years preceding the grant awards.

The legislation mandates that:

- States use 15 percent of their grant to provide health and support services to infants, children, women and families with HIV disease;
- States reporting 1 percent or more of all U.S. AIDS cases use 50 percent of their CARE grant to fund consortia that received assistance from the previously funded HRSA adult/pediatric HIV care providers, people with HIV/AIDS, and community organizations that offer services to HIV patients.
- States may use CARE grant funds for home and community based care services, to continue health insurance premiums and coverage for people with HIV/AIDS, and to provide and coordinate care and drug treatments that prolong life or prevent serious deterioration of health for those with HIV disease; and
- States are to balance the needs of urban areas with those of rural areas.

Annual Performance Goals and Performance Indicators:

Performance Goals:

Client-oriented Goals: To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

A. Increase the number of ADAP utilizers receiving appropriate anti-retro viral therapy (consistent with clinical guidelines) through State ADAPs during at least one month of the year, to a projected level of 57,500 people in 1999. (Baseline: 41,000 in 1997)

   Indicator:
   Number of individuals receiving appropriate anti-retro viral therapy (consistent with current clinical guidelines) through State ADAPs.

B. Combination Drug Therapy: As discussed in the note in the introduction to the HIV/AIDS section, the Agency is considering ways to measure not only who is served by the Ryan White CARE Act Drug Assistance Program, but who may need those services but not receive them. Measuring unmet need for the AIDS Drug Assistance Program (ADAP) is problematic from a data collection and methodological standpoint, as well as the factors involved in provider decision making on eligibility. Decisions by practitioners are individualized to patient circumstances. Providers need to assess the

individual patient's ability to benefit from, and remain compliant with, complex drug treatment protocols involving medications with potentially severe side effects.

The HIV/AIDS Bureau will continue to explore options to evaluate unmet need for ADAP services through current data collection efforts and future planning for new data collection activities, and welcomes suggestions on ways to approach this.

Provider-oriented Goals: To assure improved delivery of services and increased access to services as a result of the CARE Act.

C. Increase the number of visits for medical care from an estimated 424,500 in 1996 to a projected 458,000 in 1999, a 7.9 percent increase.

Indicator:
Number of visits for medical care.

D. Increase the total number of unduplicated clients served by the Health Insurance Continuation Programs for People with HIV from an estimated 6,096 in 1996 to a projected 8,958 in 1999, a 46.9 percent increase.

Indicator:
Number of unduplicated clients served by the Health Insurance Continuation Programs for People with HIV.

E. Increase the total number of unduplicated clients served by the Title II Consortia and Home- and Community-Based Care Programs from an estimated 291,600 in 1996 to a projected 314,990 in 1999, an 8.0 percent increase.

Indicator:
Numbers of unduplicated clients served by the Title II Consortia and Home- and Community-Based Care Programs. (NOTE: numbers related to this performance goal are estimated unduplicated within Title II; the extent of duplication with Title I or other CARE Act Titles is not known).

System-oriented Goal: To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

F. Serve women and people of color in Title II funded programs in proportions that exceed their representation in overall AIDS seroprevalence by a minimum five percentage points (e.g., if 15 percent of overall AIDS cases are among women, serve 20 percent women in Title II programs).

Indicator:
Number and proportion of women and people of color in Title II funded programs; number and proportion of women and people of color of the total population who are Seropositive.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

One of the draft strategic objectives is that:

- By 2003, HRSA will assure that HIV-associated morbidity will be decreased by 50 percent.

This program is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs; Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation: data for Goals A-F are obtained from the following sources:

- Annual Administrative Reports
- Grant Applications
- Grantees' Needs Assessments

1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

Authorizing Legislation: Sections 2611-2619 of the Public Health Service Act.

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
	$543,000	$127,000	$670,000
ADAP	($285,500)	($100,000)	($385,500)

Annual Performance Plan: FY 1999 Budget

Program Activity: AIDS: HIV Early Intervention Services (Part C)

Description of Program Activity:

Title III of the Act authorized a program to support outpatient HIV early intervention services. The program specifically targets previously underserved populations, which have had limited access to care, including women, children, adolescents, people of color, and substance abusers.

The 166 Title III programs represent a cross-section of community-based organizations. They include: 1) Federally-funded community health centers, 2) non-federally funded community-based health centers; and city and county health departments, 3) hospital or university-based medical centers, 4) other types of organizations including - health care for the homeless centers, family planning clinics, and comprehensive hemophilia diagnostic and treatment centers.

Annual Performance Goals and Performance Indicators:

Performance Goals:

Client-oriented Goals: To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

A. In FY 1999, increase by 5 percent over 1998 figures to a level of 79,000, the number of people receiving primary care services under HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS Programs.

   (Baseline: In FY 1997, over 73,000 people living with HIV/AIDS received primary care services in HRSA HIV/AIDS (Ryan White CARE Act) EIS programs.)

   Indicator:
   Change in number of people receiving primary care services under HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS Programs.

B. In FY 1999, increase by 5 percent over 1998 figures the number of persons receiving primary care services under HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS programs, who are also receiving combination antiretroviral therapy (e.g. including protease inhibitors).

   (Baseline data available for this measure in 1998)

   Indicator:
   Change in number of persons receiving primary care services under HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS programs, who are also receiving combination antiretroviral therapy (e.g. including protease inhibitors).

Provider-oriented Goal: To assure improved delivery of services and increased access to services as a result of the CARE Act.

C. In FY 1999, increase by 5 percent the number of HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS clients/patients who are offered the opportunity and are eligible to participate in HIV/AIDS clinical trials/research.

(In CY 1995, almost 5 percent of the PLWH receiving primary care services in HRSA HIV/AIDS [Ryan White CARE Act] EIS programs were referred to facilities and institutions to participate in HIV clinical trials and research.)

Indicator:
Change in number of HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS clients/patients who are offered the opportunity and are eligible to participate in HIV/AIDS clinical trials/research.

System-oriented Goals: To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

D. In FY 1999, provide 2-3 planning grants to communities not currently receiving HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS funds.

(Four planning grants were funded in FY 1996 - the first year they were authorized.)

Indicator:
Number of planning grants to communities not currently receiving HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS funds.

E. In FY 1999, increase by 6-8 the number of HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS grants to areas not currently receiving Ryan White Title I or III funds.

(In FY 1997, 166 HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS programs were funded in 37 states, the District of Columbia and Puerto Rico.)

Indicator:
Change in number of HRSA HIV/AIDS (Ryan White CARE Act-Title III) EIS grants to areas not currently receiving Ryan White Title I or III funds.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

Draft strategic objectives include:

- By 2003, HRSA will assure that HIV-associated morbidity will be decreased by 50 percent.

- By 2002, HRSA will assure that 75 percent of people receiving HIV positive test results will have a primary care visit within 6 weeks.

This program is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs; Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation:

- HRSA HIV/AIDS (Ryan White CARE Act) Title III Program Annual Data Report
- Program Information

1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$76,300	$10,000	$86,300

Annual Performance Plan: FY 1999 Budget

Program Activity: AIDS: HIV Pediatric Grants (Women, Children and Youth)

Description of Program Activity:

The purpose of the HIV Program for Children, Youth, Women, and Families is to improve and expand the infrastructure of comprehensive care services in order to increase the access of HIV/AIDS-affected women, infants, children, and youth to a comprehensive, community-based, family- centered system of care. These individuals require more intensive case management, child and respite care and direct service delivery. The focus of the program has further expanded to develop innovative models that link systems of comprehensive community-based medical and social services for the affected population with the National Institutes of Health and other clinical research trials. Funds support innovative strategies and models to organize, arrange for, and deliver comprehensive services through integration into ongoing systems of care.

Projects funded in fiscal year 98 will include: Grants for Coordination of HIV Services and Access to Research for Children, Youth, Women and Families; cooperative agreements with national resource centers; Women's Initiative for HIV Care and Reduction of Perinatal HIV Transmission (WIN); adolescent research sites (REACH) funded through an interagency agreement with NIH; and a new initiative targeting comprehensive services for HIV-infected youth.

Annual Performance Goals and Performance Indicators:

Performance Goals:
Client-oriented Goal: To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

A. Increase by 15 percent the number of women provided comprehensive services, including appropriate counseling before or during pregnancy, about prevention of perinatal transmission. (Baseline: 21,500 women were counseled in 1995)

   Indicator:
   Number of women provided comprehensive services, including appropriate counseling before or during pregnancy, about prevention of perinatal transmission.

Provider-oriented Goals: To assure improved delivery of services and increased access to services as a result of the CARE Act.

B. Increase by 15 percent, enrollment in comprehensive, coordinated systems of care for HIV-positive youth and young adults under age 24 (and their families). (Baseline: 4480 enrolled adolescents in 1995)

   Indicator:
   Numbers of HIV-positive youth and their families enrolled in comprehensive, coordinated systems of care.

C. Decrease by 8 percent, the number of newly reported AIDS cases in children as a result of perinatal transmission. (Baseline: 678 cases in 1996)

Indicator:
Numbers of reported AIDS cases in children as a result of perinatal transmission.

System-oriented Goal: To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

D. 60 percent of projects reach or exceed their goals for offering clients opportunities to participate in and enroll in research trials where appropriate. (Baseline: 4 projects in 1997)

Indicator:
Percentage of projects that reach or exceed their goals for offering clients opportunities to participate in and enroll in research trials where appropriate.

Link to Strategic Goals and Objectives:
The above program specific performance measures are supportive of the following HRSA Strategic Goals:
- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

This program is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs; Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation:
- CDC HIV/AIDS Surveillance Report
- Title IV mandatory Data Report
- Title IV mandatory Data Report

1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$41,000	$3,000	$44,000

Annual Performance Plan: FY 1999 Budget

Program Activity: AIDS: Special Projects of National Significance

Description of Program Activity:

The CARE Act directs that up to 10 percent of appropriated Title II funds be used to support a competitive grant program, Special Projects of National Significance (SPNS). The SPNS projects are expected to: (a) build programs of care that address special care needs of individuals with HIV; (b) serve special populations; or © organize care in new and innovative ways. The results of the SPNS demonstrations are expected to be disseminated so that they can be replicated in other areas.

Annual Performance Goals and Performance Indicators:
Performance Goals:

System-oriented Goals: To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

A. In FY 1999, a minimum of 50 innovative projects will receive grant funding to test models of HIV service delivery.

   (Baseline: 57 projects in FY 1997)

   Indicator:
   Number of innovative projects that receive grant funding to test models of HIV service delivery

B. In FY 1999, the number of grants to community based organizations (CBO) will increase by 15 percent - because community based organizations are an important aspect of evaluating innovative models.

   (Baseline: 21 total CBO grantees in FY 1997.)

   Indicator:
   Number of grants to community based organizations (CBOs).

C. In FY 1999, information on 100 percent of the service delivery models being tested will be disseminated nationally.

   Indicator:
   Percentage of service delivery models being tested for which information was disseminated nationally.

D. In FY 1999, an assessment of HIV service system needs based on feedback from CARE Act grantees will be completed.

   (Baseline: last assessment completed in FY 1994.)

Indicator:
An assessment completed of HIV service system needs based on feedback from CARE Act grantees.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

This program is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs; Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation: data for all four of the goals are obtained from the following:

- Grant Applications
- Grantee Evaluation Reports
- Number of training sessions, manuals, and technical assistance workshops given by SPNS Program grantees.

1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

Authorizing Legislation - Section 2691 of the Public Health Service Act.

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
($25,000)	---	($25,000)

Annual Performance Plan: FY 1999 Budget

Program Activity: AIDS Education and Training Centers

Description of Program Activity:

The National AIDS Education and Training Centers (AETC) Program is a network of 15 regional centers (with more than 75 local performance sites) that conduct targeted, multi disciplinary HIV education and training programs for health care providers. The mission of these centers is to increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat and manage individuals with HIV infection and to assist in the prevention of high risk behaviors which may lead to infection. Goals of the Program include:

- to provide training to increase diagnosis, treatment and management of HIV infection and to offer interventions that will prevent HIV infection;
- to disseminate state of the art HIV information to providers; and,
- to develop HIV provider materials.

Annual Performance Goals and Performance Indicators:

Performance Goals:

Client-oriented Goal: To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

A. In FY 1999, show that at least 40 percent of those health care providers who attended AETC clinical training programs improved the quality of HIV care they provided.

   Indicator:
   Percent of health care providers who attended AETC clinical training programs, who improved the quality of HIV care they provided. (Quality indicators will be collected through a program-wide longitudinal evaluation system which will be developed and initiated by Oct 1, 1998.)

Provider-oriented Goals: To assure improved delivery of services and increased access to services as a result of the CARE Act.

B. In FY 1999, develop and conduct, in collaboration with CDC, NIH (NLM,OAR,NAIAD), HCFA, FDA, SAMHSA, IHS, and AHCPR, at least two nationwide satellite information dissemination broadcasts to downlink sites throughout the country. The target audience will be health care providers providing care for PLWH/A and covering pertinent HIV topics such as “practice policies” and “reducing perinatal transmission”.

   (As of 1997, no national satellite broadcasts were conducted.)

Indicator:
Number of nationwide satellite information dissemination broadcasts downlinked to sites throughout the country, which were developed and provided in collaboration with other Federal agencies.

C. In FY 1999, develop an HIV/AIDS educational resource library on the Internet, containing AETC curricula and slide sets. This resource library will be targeted toward health care providers and medical/nursing faculty.

(Currently, no HIV/AIDS educational resource library exists.)

Indicator:
Creation of an HIV/AIDS educational resource library on the Internet, containing AETC curricula and slide sets.

D. In FY 1999, increase by 10 percent the percentage of minority health care providers who receive training in AETCs.

(In FY 1995, approximately 30 percent of provider attendees were minority health care providers.)

Indicator:
Number of minority health care providers who receive training in AETCs; total number of health care providers who receive training in AETCs.

System-oriented Goal: To increase the ability of service delivery systems to respond to HIV/AIDS-related epidemiology and therapeutic advances.

E. In FY 1999, 100 percent of AETCs will provide a wide range of programs on new treatment modalities including: combination drug therapy, protease inhibitors, and treatments to prevent the vertical transmission of HIV.

(In FY 1999, training modules will be developed for health care providers, in anticipation of the publication of new guidelines for the standards of treatment for triple drug therapy using protease inhibitors for adults and some form of combination drug therapy to reduce the vertical transmission of HIV to children. The publication of new guidelines is anticipated in late 1997.)

Indicator:
Number of AETCs that provided a wide range of programs on new treatment modalities including: combination drug therapy, protease inhibitors, and treatments to prevent the vertical transmission of HIV.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

This program is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs; Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation:

- AETC Program Data System
- AETC Satellite broadcast reports and evaluations
- AETC Program Data System
- AETC Evaluation Data System

1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$17,300	---	$17,300

Annual Performance Plan: FY 1999

Program Activity: AIDS - Dental Services Program

Description of Program Activity:

Section 2692, Title XXVI of the Public Health Service Act authorizes the Secretary to make grants to assist accredited dental schools and post-doctoral dental education programs to meet uncompensated costs for providing oral health care to HIV infected individuals. The Secretary shall distribute available funds among all eligible applicants taking into account the number of HIV infected patients served and the unreimbursed oral health costs incurred by each institution as compared to the total number of HIV infected patients and costs incurred by all eligible applicants.

The program is designed to reimburse accredited dental schools and other post-doctoral dental education programs for the documented uncompensated costs they have incurred for providing oral health treatment to HIV infected patients for twelve-month periods which are specified annually.

Annual Performance Goals and Performance Indicators:

Performance Goals:
Client-oriented Goal: To improve the health and quality of life of people living with HIV/AIDS who are receiving CARE Act-funded services.

A. Maintain support to institutions for the unreimbursed cost of dental care provided to HIV positive patients.

   Baseline: In 1996, the HRSA HIV/AIDS [Ryan White CARE Act] Dental Reimbursement Program provided an average award of 46 percent of unreimbursed costs to 102 institutions in support of dental care for HIV positive patients.

   Indicator:
   Unreimbursed cost to institutions for dental care to HIV positive patients prior to additional funding support provided by HRSA HIV/AIDS Dental Reimbursement Program HRSA; amount of HRSA HIV/AIDS Dental Reimbursement Program funding support to institutions for unreimbursed cost provided for dental care to HIV positive patients.

Provider-oriented Goals: To assure improved delivery of services and increased access to services as a result of the CARE Act.

B. Encourage new community partnerships with training programs and encourage recipients to seek additional funding support from alternative sources to pay for 50 percent of the costs of unreimbursed dental care.

   (In 1996, 50 percent of Dental Reimbursement Programs established community partnerships with training programs.)

Indicator:
Number of Dental Reimbursement Programs establishing new community partnerships with training programs; number of recipients seeking additional funding support from alternative sources to pay for 50 percent of the costs of unreimbursed dental care.

C. Each dental institution funded under this program will offer a minimum of one post-graduate HIV dental training program during 1999 with curriculum content that increases graduates' knowledge of the latest HIV procedures and reduces anxiety of treating individuals with HIV.

(Baseline data will be available in 1997.)

Indicator:
Number of dental institutions funded under this program that offered a minimum of one post-graduate HIV dental training program during 1999 with curriculum content that increases graduates' knowledge of the latest HIV procedures and reduces anxiety of treating individuals with HIV.

D. Programs receiving Dental Reimbursement will increase the percentage of restorative and periodontic procedures provided to HIV positive patients at levels similar to the non-HIV patients in the general population.

(In FY 1996 the percentage of oral health distribution of procedures provided to patients for care provided during July 1994 to June 1995 was as follows:

Procedure	Percent Distribution of HIV-infected patients	Procedures Provided General Population
Restorative	**14.1%**	**18.5%**
Periodontics	**9.9%**	**8.5%**

Indicator:
Number of programs receiving Dental Reimbursement that maintain the percentage of restorative and periodontic procedures provided to HIV positive patients at levels similar to the non-HIV patients in the general population.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

This program is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation’s health entitlement and safety net programs; Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific needs.

Data Collection and Validation:

- Program applications: Goals - A,B and D
- Evaluation study to be completed in FY 1997: Goals C and D

1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$7,800	---	$7,800

MATERNAL AND CHILD HEALTH

Annual Performance Plan: FY 1999 Budget

Mission and Overview

The Maternal and Child Health Bureau (MCHB) provides leadership, partnership and resources to advance the health of all of our Nation's mothers, infants, children, and adolescents-including families with low income levels, those with diverse racial and ethnic heritage and those living in rural or isolated areas without access to care.

The Bureau draws upon nearly a century of commitment and experience. Early efforts are rooted in MCHB's predecessor, the Children's Bureau, established in 1912. Major program efforts of the Bureau include:

- The Maternal and Child Health Block Grant - Title V
- Emergency Medical Services for Children
- Healthy Start
- Traumatic Brain Injury Program
- Abstinence Education Program

Program Activity: Title V Maternal and Child Health Block Grant

Description of Program Activity:

The Maternal and Child Health (MCH) Block Grant program is administered as a Federal-State partnership to improve the health of all mothers, children and adolescents, consistent with the national health objectives for the year 2000. The Block Grant aims to make a major difference in the lives of all families and, in particular, to low-income recipients for whom access to comprehensive health services requires more than financing mechanisms. The MCH Block Grant provides leadership in strengthening and reshaping the system of care and linking Federal/State/local and private programs to improve the health of mothers and children, thereby creating an environment that encourages the reduction of risky behaviors, promotion of optimal growth and development, prevention of disease and disability, and achievement of the Healthy Children 2000 objectives.

The MCH Block Grant is an important component of the Secretary's Children's Health Initiative to insure and provide services to 5 million of the 10 million uninsured children over the next four years. Financing alone is not enough to assure access to services and provide a "health home" for these newly insured children. There must be an outreach effort to bring children into a health care home and maintain them there; a capacity building effort to assure the availability of a health care home; and increased population based community programs for children that complement the work of their health home providers.

Title V of the Social Security Act provides that the amount appropriated for the MCH Block Grant be used as follows: Of the amount appropriated up to $600 million, 85 percent is for allocation to the States and 15 percent is for the

special projects of regional and national significance (SPRANS) Federal set-aside; for the amount appropriated over $600 million, 12.75 percent is for the community integrated service systems (CISS) Federal set-aside program, and of the remaining amount 85 percent is distributed to the States and 15 percent for SPRANS.

There are three major areas where the Maternal & Child Health (MCH) Block Grant funds are required to assist States:

1. Children's needs for health care coverage, a health care home and quality care.

   - In 1995, 14 percent of all children--approximately 10 million children--were not covered by health insurance and were either ineligible or not enrolled in publicly financed medical assistance programs. These children resided in every community in every State. While most of these children were members of working families whose parents could not afford health insurance, roughly 3 million were estimated to be eligible for Medicaid.

   - There is increasing evidence that there is an inadequate number of providers and health homes for children who have, or may become newly eligible for, coverage and that the speed with which children are being moved into managed care has resulted in a decline in the quality of care. Consequently, there is an unmet need for more guidance on what constitutes appropriate care and on how to monitor quality of care.

   Related to these needs are these additional factors:

   - Compared to their insured counterparts, uninsured children are less likely to access primary care services and are at increased risk for receiving lower quality care.

   - As a result of their inadequate health care, children without health insurance are more susceptible to disease and experience more severe consequences from injury than their insured peers.

   - Health care coverage in an appropriate health care home, including ambulatory, hospital, enrollment outreach, enabling services, and health assurance services is estimated to cost about $1,355 per child annually.

2. Other maternal and child health care needs identified by the States and by national data.

   Every five years each State is required to perform a maternal and child health needs assessment, which leads to the identification of State priorities. A review of the most recent of these has identified the following high priority issues among the States:

   - low birth weight and infant mortality;
   - access to care;

- prenatal care;
- reduction of unintended pregnancy;
- specific critical health concerns such as lead poisoning and dental care;
- identification of and treatment for HIV-infected mothers and children;
- injury prevention;
- substance abuse;
- immunization;
- maternal health risks;
- family education and support; and
- high-risk adolescent behavior.

These State-identified priority areas are reinforced by other data:

- Declines in minority health status.

- Increases in deaths due to unintentional injuries. 110,503 deaths of children between 1-9 years old with the top cause (15.9 percent aged 1-4 and 8.9 percent aged 5-9) being unintentional injuries and 18,865 deaths of adolescents between 10-19 years old with the top cause (9.7 percent aged 10-14 and 36.5 percent aged 15-19) being unintentional injuries.

- Increases in dental diseases. Dental caries is the most prevalent disease among children and 75 percent of this disease occurs in 20 percent of the children, most of whom are in low-income, at risk populations. For the first time in more than three decades, dental caries in children under 5 years of age has increased, while access to dental services has been on the decrease.

- Decrease in childhood fitness. The number of seriously overweight children and adolescents in the U.S. has more than doubled in the past three decades, with most of the increase occurring since 1980. Participation in all types of physical activity declines strikingly as age or grade in school increases.

- Decreases in access to physicians. 13.1 million children (19.6 percent) under the age of 20 years, including 7.5 percent of white, 8.6 percent of black and 7.9 percent of Hispanic origin children aged 1-4, did not see a physician in 1993.

And again, there are additional related socioeconomic events:

- Increases in child poverty. In 1993, 15 million children lived below the poverty line (more than one child in five), an increase from 12.7 million in 1990. Among children under three, more than one in four lives in poverty.

- Increases in children and adolescents who are financially cut-off from health services, with more than 14 percent of all children in the U.S. not having health insurance coverage.

3. State training, data, resource and knowledge needs.

In recent years the States have been given increased responsibilities resulting from the delegation of federal programs to the States and State health care reforms, while at the same time a large number of State and community health departments are undergoing significant reorganizations. States need to strengthen their ability to develop new programs, contain costs, manage new State programs, and help implement and manage local health care reforms. This will require staff retraining, data development, resource and knowledge development. To accomplish this, States need to rebuild their organizations, add new management tools, develop new staff capacity and skills as well as resources. States will need to increase their knowledge of the appropriate technology/methodology, refurbish eroded training programs, obtain equipment to monitor enrollees, provide or ensure services to children with special health care needs, and coordinate community support for families in need of care. To meet these needs they will be required to assess quality, measure performance, redesign systems for the uninsured, develop guidances and standards, reestablish deteriorated regional perinatal care systems, and develop distance learning and data collection capabilities.

The MCH State block grant gives States the flexibility to address those problems that they have identified as priority needs. To the extent possible, the Maternal and Child Health Bureau (MCHB) will encourage State MCH officials to focus greater attention and stimulate new activities on those areas of need in their State that relate to providing services to the 5 million children targeted in the Children's Health Initiative. Funding will enable them to strengthen leadership roles and undertake activities such as:

- Outreach activities to find the three million children who are eligible for, but not enrolled in, Medicaid and help enroll them in a comprehensive Medicaid health care home, a role that MCH Departments must play by law.

- Oversight and assessment activities to identify areas where inadequate or no health homes exist for newly enrolled children.

- Leadership activities to develop data and call together purchasers, providers and patients to reach agreements that as children become enrolled in Medicaid or receive private health insurance they will be encouraged and able to enroll in quality health homes.

- Capacity/infrastructure building activities that strengthen the development of health homes and systems integration to provide health home options for newly enrolled children.

- Preventive care program development and implementation to promote population-based public health initiatives to assure a health community, particularly in the areas of the "Back to Sleep" campaign, injury prevention, disability prevention such as newborn hearing screening which States have already begun.

Title V supported agencies and projects are pivotal in building the systems capacity to ensure that women and children are receiving quality care. With the recent changes in Medicaid from fee for service to managed care, new contracts, guidelines and standards are badly needed by the States to handle their new oversight and increased assurance roles. Funding would be used to stimulate increased State activity in this area, particularly in the development of data systems to support and monitor quality activities, and to develop guidances for providing quality care to children with special health care needs. However, since some States are further behind in these efforts than others, some funding would also be used to educate State officials in how to develop and use quality standards and new data systems for assisting and monitoring managed care organizations in the area of quality assurance.

The SPRANS and CISS components of the MCH Block Grant program are used by MCHB to provide leadership and direction to the MCH community in addressing and meeting new and emerging national needs and issues impacting on maternal and child health. The Maternal and Child Health Bureau, based on both State-identified and national data, identifies specific high priority areas to which the resources of the SPRANS and CISS program are targeted. These priority areas, as well as the mechanisms used to address them, may change slowly over time. The mechanisms may take the form of: data monitoring to identify emerging issues; national consensus conferences to more fully clarify issues and develop strategies; targeted research in specific areas; development of standards and guidelines; service delivery or system improvement demonstrations and evaluations; technical assistance to meet specific State agency needs; long-term training and continuing education to provide or update needed skills or capabilities; support to the States to introduce or implement new strategies and capabilities; publication and dissemination of findings, guidelines, and standards; etc. The flexibility of the SPRANS and CISS components of the MCH Block Grant is essential to the Bureau’s ability to respond quickly to new threats to maternal and child health.

Annual Performance Goals and Performance Indicators:

An initial set of MCHB GPRA measures has been identified to measure the national impact of the MCH State Block Grant program. These measures are based on a core set of measures that the States will start reporting on, under the new Performance Partnership with the States, in FY 1998. The State core measures have been developed during a 16 month process in which representatives of the States, concerned interest groups, experts in public health, maternal and child health, public health data, and State data systems all participated. The process included two major meetings with representatives of all the State maternal and child health Directors, and extensive discussions with and input from the States. It also included a pilot-test of the new Block Grant Report and Application Guidance developed in conjunction with this new Performance Partnership. The MCHB GPRA measures for the MCH State Block Grant program will aggregate and use the State core measures to assess the overall performance of the whole State Block Grant program.

Performance Goals:

The MCHB GPRA measures developed for the MCH State Block Grant program include:

A. Collect data on a set of State core, or benchmark, performance measures (see list below) for the Block Grant from all States, and assess progress against the baselines for these measures in each State.

STATE CORE PERFORMANCE MEASURES, to be reported in FY 1998

1. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

2. The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

3. The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical home.”

4. Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g, the sickle cell diseases) (combined).

5. Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

6. The birth rate (per 1,000) for teenagers aged 15 through 17 years.

7. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

8. The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

9. Percentage of mothers who breastfeed their infants at hospital discharge.

10. Percentage of newborns who have been screened for hearing impairment before hospital discharge.

11. Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

12. Percent of children without health insurance.

13. Percent of potentially Medicaid eligible children who have received a service paid for by the Medicaid Program.

14. The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

15. The rate (per 100,000) of suicide deaths among youths 15-19.

16. Percent of very low birth weight live births.

17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Indicator:
Data collected on Core performance measures from all States, with progress assessed against baselines for these measures in each State.

B. Improve access to health care through systems development by increasing to 70 percent the proportion of State/MCH programs that have written interagency agreements with Medicaid, WIC, and other Human Services agencies.

Indicators:
- Proportion of State/MCH programs with written interagency agreements with Medicaid
- Proportion of State/MCH programs with written interagency agreements with WIC agencies.

C. Improve health status by showing improvement in two of six Outcome measures (listed below) in 60 percent of the States.

- The Infant Mortality Rate
- The ratio of the Black infant mortality rate to the White infant mortality rate
- The Neonatal Mortality Rate
- The Postneonatal Mortality Rate
- The Perinatal Mortality Rate
- The Child Death Rate for children aged 1-14.

Indicator:
Proportion of States showing improvement in two of the six identified Outcome measures.

D. Improve access to selected services by increasing the levels of two of the four indices (listed below) in 70 percent of states.

- Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
- The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical home."
- Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.
- Percent of children who have received protective sealants on at least one permanent molar tooth.

Indicator:
Proportion of States increasing the levels of two of the four identified indices.

E. Maintain excellence by reporting a 100 percent follow-up rate for disorders screened in the newborn (PKU, galactosemia, hypothyroidism) in 70 percent of State MCH programs.

Indicator:
Proportion of States reporting a 100 percent follow-up rate for identified disorders screened in the newborn.

Additional MCHB GPRA measures for the SPRANS and CISS portions of the Title V Block Grant will be determined and developed over the next year. The development of MCHB GPRA performance measures, and selection of performance indicators, will logically follow the development of the strategic plan for implementing the new Children's Health Initiative, the quality care initiative, and other newly emerging MCH SPRANS and CISS priorities. As specific priorities are identified, and as criteria and activities for accomplishing the program's goals are clarified, appropriate measures will be identified. After testing and identification of appropriate data sources, together with revisions and development of any new data mechanisms, we should have our measures developed and ready for use.

Link to Strategic Goals and Objectives:

Generally, this program is supportive of HRSA's Goal 1: Eliminate Barriers to Care; HRSA's Goal 2: Eliminate Health Disparities; and HRSA's Goal 3: Assure Quality Care.

The MCH Block Grant is also supportive of a number of goals in the Department Strategic Plan. It is supportive of Goal 1: Reduce the major threats to the health and productivity of all Americans, including Strategic Objective 1.2: Reduce the number and impact of injuries, and Strategic Objective 1.6: Reduce unsafe sexual behaviors. It is also supportive of Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement

and safety net programs, including Strategic Objective 3.2: Increase the availability of primary health care services, and Strategic Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific health care needs.

Data Collection and Validation:

Data for performance measures A through E will be provided by the States as part of the Performance Partnership requirements or, in the case of vital statistics data, obtained from CDC. Initial data for all States will be received in 1998, providing baseline data for these measures. For the additional measures to be developed covering the Children's Health Initiative, the quality care initiative, as well as other newly emerging MCH SPRANS and CISS priorities, data necessary to establish baselines will be identified and collected as soon as performance indicators are selected.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$683,000	---	$683,000

Annual Performance Plan: FY 1999 Budget

Program Activity: Emergency Medical Services for Children

Description of Program Activity:

It seeks to improve all aspects of children's emergency medical care, including pre-hospital care, emergency department care, hospital care, and rehabilitation, and it seeks to prevent such emergencies from occurring. The program mission is to reduce child and adolescent mortality and morbidity sustained due to severe illness or trauma.

Pediatric emergency care has many deficiencies. For example, EMTs (emergency medical technicians) and paramedics are often not adequately prepared to treat children:

- Only two states require that Basic Life Support (BLS) vehicles carry all equipment needed to stabilize a child and only five States require all such equipment for Advanced Life Support (ALS) ambulances.
- Thirty-four percent of EMTs and paramedics reported in a 1997 national survey that they do not feel comfortable treating children.
- In 1996, 66 percent of persons who failed the national EMT exam did so because they failed the pediatric/obstetrics section.
- A study completed in 1996 found that paramedics' skills and knowledge for treating critically ill or injured children completely decayed by six months post-training. Yet no State requires even annual retraining in pediatric care.
- Children with special health care needs present major complications for emergency treatment. Yet only six States have approved continuing education courses that address this topic.

Systems are not in place to ensure prompt, appropriate emergency care for children. For example:

- Only 11 States have guidelines for acute care facility identification for pediatrics to ensure that children get to the right hospital in a timely manner.
- Less than half (46 percent) of hospitals with emergency departments have necessary equipment for stabilization of ill and injured children.
- Only 40 percent of U.S. hospitals with emergency departments have written transfer agreements with a higher level facility to ensure that children receive timely and appropriate hospital care when they need it.
- Thirty-two percent of EMTs and paramedics report that they do not feel that their EMS system is adequate for treating children.

Critical illness and injury are significant problems for children. For example:

- 20,000 children (under age 19) die each year from injury.
- 14 million children are injured seriously enough each year to require medical intervention.
- 31.4 million children visit a hospital emergency department each year.

Systems are not in place to assess and evaluate pediatric emergency care. For example:

- Only nine States have the capacity to produce reports on pediatric EMS using Statewide EMS data.

The EMSC program provides grants to States and schools of medicine to foster changes to the EMS system. The program also uses its resources to work with professional associations to address issues such as improved training and development of policies and standards. The program has developed a strategic plan focused on the system changes needed to improve pediatric emergency care. Each strategic goal in this plan includes a set of measurable objectives (or performance goals), most of which have a five-year time frame, reflecting the time required to achieve changes in EMS systems. The grant program can have some impact on many of the performance goals, but without the assistance of various national groups, the grant program by itself will ultimately be unsuccessful in changing pediatric emergency services. For this reason, the EMSC program has developed collaborative activities with both professional associations and other government agencies through contracts and interagency agreements.

Since many of the changes that are desired will take some time to accomplish, annual measurement will not show much effect: **capacity** is best measured over a 5-year period, which we intend to do. We have conducted several surveys and special studies in order to obtain baseline data for the performance goals. We will measure **outputs** annually through grant reporting requirements; these will consist of the number of States that can demonstrate activity related to each performance goal. The output measures are proxies documenting movement towards meeting the capacity goals. Eventually we will have to link these changes in capacity to measures of the relevant health outcomes.

Annual Performance Goals and Performance Indicators:

Performance Goals	Performance Indicators	FY Target	1997 Baseline
A. Increase the number of States that require training in pediatric emergency care as a condition for recertification of EMTs at all skill levels.	**Output:** Number of States working on this issue through grants	1999: 6	0
	Capacity: Number of States requiring training for recertification	2002: 10	0
B. Increase the number of States with approved continuing education programs for EMS providers on care of technology-assisted children	**Output:** Number of States working on this issue through grants	1999: 9	6
	Capacity: Number of States with approved programs	2002: 12	6
C. Increase the number of States that require all EMSC-recommended equipment deemed essential on ambulances.	**Output:** Number of States working on this issue through grants	1999: 20	7
	Capacity: Number of States with regulatory requirements.	2002: 50	2 for BLS; 5 for ALS*
D. Increase the number of hospitals that have inter-facility transfer guidelines for critically ill and injured pediatric patients.	**Output:** Number of States working on this issue through grants	1999: 15	5
	Capacity Number of hospitals with guidelines.	2002: 60%	40%
E. Increase the number of States that have implemented pediatric guidelines for acute care facility identification.	**Output:** Number of States working on this issue through grants	1999: 15	8
	Capacity: Number of States with guidelines.	2002: 25	11
F. Increase the number of States using data linkage methodology to describe and evaluate EMSC.	**Output:** Number of States working on this issue through grants	1999: 20	11
	Capacity: Number of States using data linkage	2002: 15	9

*BLS = Basic Life Support; ALS = Advanced Life Support

Performance Strategies for Achieving Goals: We have initiated a new category of grants, "Partnership Grants," that we will be able to make available to all States to enable them to work on these performance goals. In addition, we will continue to work with professional associations to assist them in addressing these and other EMSC issues with their membership and through their policy committees.

Resources Required for Achieving Goals: Present funding is used for initial systems development activities, research, technical assistance, contracts with professional associations, and development of national models. "Partnership" grants to States, currently funded at only $60,000 per year, are designed to enable each State to address the performance goals that it has not yet met and that are identified as most significant by the State.

Link to Strategic Goals and Objectives:

Generally, this program is supportive of HRSA's Goal 1: Eliminate Barriers to Care; and HRSA's Goal 3: Assure Quality Care. It is also supportive of the Department's Strategic Plan, particularly Goal 1: Reduce the major threats to the health and productivity of all Americans, including Strategic Objective 1.2: Reduce the number and impact of injuries. It is also supportive of Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs, including Strategic Objective 3.2: Increase the availability of primary health care services, and Strategic Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific health care needs.

Data Collection and Validation:

In order to collect national-level data for many of the plan's objectives, national surveys and special studies will have to be undertaken. **Output** indicators can be collected from States as a part of their regular, annual reporting requirements. **Capacity,** and also **outcome**, indicators, however, which actually identify success or failure of the program, can presently only be collected through special surveys and studies. This is expensive in terms of both staff and financial resources. In FY 1997, several special studies were undertaken to collect baseline capacity data. These included surveys of grantees and of State EMS directors. In addition, a special study of a stratified random sample of hospital emergency departments was undertaken in collaboration with the Consumer Product Safety Commission. It is planned that these studies will be done again in FY 2000. Output indicators are easily collected and pose no validity concerns. To collect valid capacity indicator data, however, requires considerable planning and pilot testing to ensure validity.

We recognize that the capacity measures proposed have not yet been directly linked to health outcomes such as reduced child and adolescent mortality and morbidity sustained due to severe illness or trauma. This means that at some point we will need to link this program to changes in health outcomes. We also know that hard data on these outcomes are not easily available. Part of our work over the summer will be to develop an approach, including a strategy for working with the States, to begin identifying potential measures and data

sources for relevant outcomes. We expect to have developed an implementation plan for getting baseline data for FY 1999 during FY 1998, and to have implemented and executed that plan in time to collect baseline data on selected health outcomes in late 1998 or early 1999.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$13,000	-$2,000	$11,000

Annual Performance Plan: FY 1999 Budget

Program Activity: Healthy Start

Description of Program Activity:

Healthy Start has been a highly successful demonstration program built on the principles of innovation, community commitment and involvement, increased access, service integration and personal responsibility. The objective is decreasing the infant mortality rate (IMR) in targeted urban and rural communities having an IMR at least 1.5 times the national average.

Approximately 300 communities, urban and rural, had an infant mortality rate (IMR) at least 1.5 times the national average for the years 1992-1994. In addition:

- In 1993, 28.9 percent of pregnant women in U.S. cities and 22.3 percent nationwide did not receive prenatal care in the first trimester of pregnancy. 6.1 percent of pregnant women in cities and 3.8 percent nationwide received no prenatal care at all. (Source: Child Health USA '95 - Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA)). Risk assessments, therefore, were late in initiation or were not performed.

- In 1993, 7.2 percent of births nationwide were classified as low birth weight; 13.3 percent of these births were to blacks. (Source: Child Health USA '95).

- In 1994, 43.3 percent of black and 41.1 percent of Hispanic related children under age 18 lived in families with income below the federal poverty level. (Source: Child Health USA '95).

- From April 1994 through March 1995, more than one million children lacked one or more doses of the recommended vaccines. (Source: Child Health USA '95).

The Healthy Start program began in 1991 as a presidential initiative. The demonstration phase (Phase I), which concluded in FY 1997, involved 22 of the more than 300 high-risk U.S. communities. They were funded to implement strategies to address the broad range of health, social, economic and educational unmet needs that result in a high infant mortality rate. The replication phase (Phase II) began in FY 1997 with 30 new communities. These projects were funded to carry out one or more of the nine effective IMR reduction strategies that emerged from Phase I. Some of the 22 demonstration projects were also awarded funds in FYs 1997 and 1998 for purposes of continuing their successful models and providing peer mentoring services to the new Healthy Start communities and other health care providers.

For FY 1999, the main purpose of the program will continue to be to reduce infant mortality, but the scope of the program will be broadened. The program will increase communities' capacity to provide health and preventive health care for pregnant women, infants and children through age 3, child care and

social services; and to integrate the quality and safe delivery of these services. Improving the quality of health and child care services within the service area would also be a focus of this program. Applicants will also be encouraged to develop programs which provide training and jobs within their communities in fields such as community outreach, child care and clerical/information services, thus expanding welfare to work opportunities.

Annual Performance Goals and Performance Indicators:

We will be implementing a process to identify, develop and implement goal-related performance measures for the Healthy Start program. While the finished statement of goals has not yet been defined, in addition to reducing infant mortality, the goals will probably include: increasing availability of health, child care and other services in high-risk communities; improving the quality of health, child care and other services in high-risk communities; improving levels of Medicaid and other program participation in these communities; and increasing the number of welfare recipients receiving training and work opportunities in their home communities.

The approach for the development and implementation of performance goals and measures is as follows:

- Identify and develop proposed performance measures for each proposed goal
- Pilot test proposed measures with select Healthy Start and/or Healthy Start eligible communities
- Identify feasible data sources or design mechanisms for data collection
- Incorporate final performance measures into grant application process and/or reporting requirements

Link to Strategic Goals and Objectives:
Generally, this program is supportive of HRSA's Goal 1: Eliminate Barriers to Care and HRSA's Goal 3: Assure Quality Care. The program is also supportive of the Department Strategic Plan. It is supportive of Goal 1: Reduce the major threats to the health and productivity of all Americans. It is also supportive of Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs, including Strategic Objective 3.2: Increase the availability of primary health care services, and Strategic Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific health care needs.

Data Collection and Validation:
Data necessary to establish baselines will be identified and collected from the first round of Healthy Start program applicants.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$95,982	---	$95,982

Annual Performance Plan: FY 1999 Budget

Program Activity: Traumatic Brain Injury (TBI) Program

Description of Program Activity:

Congress has authorized HRSA/MCHB to establish a program of demonstration grants to States to improve health and other services for the assessment and treatment of traumatic brain injury (TBI). Unlike most or all other programs administered by HRSA, and MCHB, this program applies to all Americans, and not just to one specific population group. An estimated 1.9 million Americans experience traumatic brain injuries each year -- about half of these cases result in at least short-term disability, and 52,000 people die as a result of their injuries. The direct medical costs for treatment of TBI are estimated at more than $4 billion annually. Every year, more than 90,000 people sustain injuries leading to the debilitating loss of function. As a newly established program, sources of baseline data must be identified and/or developed, data and information must be collected and analyzed, and coordinated planning must be initiated at the Federal/State/community levels.

The Maternal and Child Health Bureau has organized a Task Force to assist in the development of the TBI State Demonstration Grants Program. The Task Force, composed of organizations and individuals representing the spectrum of TBI service delivery needs, is developing a strategic plan which will be implemented for FY 1999. Although the specific goals, objectives and activities for the TBI State Demonstration Grants Program are still in development, the types of activities the States will be encouraged to undertake include: conduct of needs assessments; development of action plans; and development of TBI education and training materials. Activities to foster inter-agency collaboration and coordination to improve assessment and treatment of TBI will also be undertaken, at the Federal and State levels. The TBI State Demonstration Grants Program is not a service delivery program.

Annual Performance Goals and Performance Indicators:

The development of performance goals, and selection of performance indicators, will logically follow the development of the strategic plan for implementing the TBI program: as criteria and activities for accomplishing the program's goals are clarified, appropriate measures can be finalized.

The specific timetable for the development and implementation of performance goals and measures, while contingent on the final funding determination, is as follows:

- Agree on purposes/goals of the TBI program to be assessed
- Identify and develop proposed performance measures
- Pilot test proposed measures with select TBI programs
- Identify feasible data sources or design mechanisms for data collection
- Incorporate final performance measures into grant application process and reporting requirements

Link to Strategic Goals and Objectives:

Generally, this program is supportive of HRSA's Goal 1: Eliminate Barriers to Care. The program is also supportive of the Department Strategic Plan. It is supportive of Goal 1: Reduce the major threats to the health and productivity of all Americans, including Strategic Objective 1.2: Reduce the number and impact of injuries. It is also supportive of Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs, including Strategic Objective 3.2: Increase the availability of primary health care services, and Strategic Objective 3.3: Improve access to and the effectiveness of health care services for persons with specific health care needs.

Data Collection and Validation:

Data necessary to establish baselines will be identified and collected as soon as performance indicators are selected.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
($3,000)	---	($3,000)

Annual Performance Plan: FY 1999 Budget

Program Activity: Title V/Abstinence Education Program

Description of Program Activity:

The trends over the past several decades show that increasing proportions of teens have had sexual intercourse. Sexual experience, and particularly the age at first intercourse, represent critical indicators of the risk of pregnancy and sexually transmitted diseases (Source: Trends In The Well-Being of America's Children and Youth: 1996). After years of increases, there is some indication that teenage birth rates are finally going down, though not nearly enough. Each year, 200,000 teenagers age 17 and younger have children. The rates of sexually transmitted diseases are also declining. Still, 3 million adolescents contract a sexually transmitted disease each year. According to CDC data for 1995, the highest age-specific gonorrhea rates among females, and the second highest rates among males, occur in the 15-19 year old group: 839.7 and 498.4 per 100,000, respectively.

This program provides formula grants to States for the purpose of providing abstinence education and, at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity. The focus is on those groups which are most likely to bear children out of wedlock. This program was established by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), and was provided a permanent appropriation of $50 million for each of the fiscal years 1998-2002, which is scored as mandatory funding under the Budget Enforcement Act.

Annual Performance Goals and Performance Indicators:

Performance Goals:

A. Achieve State-set targets for reducing the proportion of adolescents who have engaged in sexual intercourse in 50 percent of the participating States.

   Indicator:
   Percentage of participating states that achieve state-set targets.

B. Achieve State-set rates for reducing the incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases in 50 percent of the participating States.

   Indicator:
   Percentage of participating states that achieve state-set rates.

C. Achieve State-set targets for reducing the rate of births to teenagers aged 15-17 in 50 percent of the participating States.

   Indicator:
   Percentage of participating states that achieve state-set targets.

Link to Strategic Goals and Objectives:

Generally, this program is supportive of HRSA's Goal 1: Eliminate Barriers to Care. It is also supportive of the Department Strategic Plan, particularly Goal 1: Reduce the major threats to the health and productivity of all Americans, including Strategic Objective 1.6: Reduce Unsafe Sexual Behaviors. It is also supportive of Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs.

Data Collection and Validation:

Data are required in the application guidance, and will be reported annually by each State in its application form.

Funding Levels Associated with this Program Effort:

($000)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
($50,000)	---	($50,000)

HEALTH PROFESSIONS

Mission and Overview

The mission of the Bureau of Health Professions (BHPr) is to provide national leadership to assure a health professions workforce that meets the health care needs of the public. Through a collection of programs and activities, the Bureau strives to improve the health status of all Americans, particularly the underserved, by enhancing the education, utilization, training, diversity, and quality of the Nation's health personnel. See Attachment A for a list of Bureau programs.

Through Titles VII and VIII programs, the Bureau provides both policy leadership and support for health professions workforce enhancement and educational infrastructure development. Current emphasis is on improving the geographic distribution and diversity of the health professions workforce. An outcome-based performance system is central to the ability of the Bureau to measure whether program support is meeting its national health workforce objectives, and to signal where program course correction is necessary.

APPROACH TO THE PERFORMANCE PLAN

The BHPr has been working for several years on the development of a comprehensive performance management system (CPMS) which is essential for measuring the outcomes of the Bureau's Titles VII and VIII health professions and nursing education programs. A demonstration will be started in FY 1998, with implementation electronically in FY 1999. At the core of the Bureau's performance management system are four cross-cutting goals with respect to workforce quality, supply, diversity and distribution. Following each of the goals, Bureau-level outcomes are proposed for capturing the common activities across programs and measuring the aggregate effects of grantee achievements in support of the goals. These are then followed by cross-cutting indicators by which the success of an outcome will be measured. See Attachment B for the National Workforce Goals, Outcomes, and Indicators.

These goals, outcomes, and indicators have been validated by representatives from health professions associations and leaders in health professions schools.

The following outcomes are viewed as most critical for the Bureau programs:

- Increase in the number of graduates and/or program completers practicing in underserved areas.

- Increase in the number of minority faculty.

- Increase in the number of minority/disadvantaged graduates and/or program completers.

The indicators associated with these outcomes are likewise of critical importance. Attachment C is a grid which shows which programs have performance goals related to the 17 cross-cutting indicators. Program

specific performance goals are included because of the current lack of cross-cutting data on which to base cross-cutting targets.

Many of the other cross-cutting indicators are either process and/or output measures. However, these measures are still considered important because of their value in explaining exceptional performance for the critical outcomes. For example, we expect that some grantees will demonstrate exceptionally high performance in placing graduates in underserved areas. We also expect that some grantees will demonstrate exceptionally low performance in placing graduates in underserved areas. Unless we can identify factors associated with exceptionally high and low performance, we will have limited ability to provide technical assistance to grantees to help improve grantee performance. With the process and output measures, we can identify, for example, if a large number of students participating in community-based continuity of care experiences may be associated with a high percentage of graduates placed in underserved areas, or if a high number of clock hours in clinical training with health care service delivery organizations serving underserved areas leads to a high percentage of graduates placed in underserved areas. Information about the factors associated with exceptional performance for the critical outcomes will be invaluable as Bureau staff provide technical assistance to grantees. We expect that such technical assistance may lead to changes in grantee project administration which will result in improved performance outcomes across the grantees in a program.

Access to health care remains a major hurdle for many Americans, particularly for vulnerable populations. The availability of a competent health workforce is essential to improving access for these populations. Pending Congressional action on configuration of Titles VII and VIII programs, the following annual performance plan presents program performance goals on a **program specific basis. Program specific performance goals are included in the Annual Performance Plan for programs covered by the CPMS and for programs not covered by the CPMS.** To the extent reauthorization provides for any consolidation of authorities, the cross-cutting indicators described above could more easily be used to demonstrate performance. Data to support the cross-cutting indicators will be collected from all grantees except those identified by an * in Attachment A.

DATA ISSUES

To collect data relative to the above cross-cutting indicators, table structures with detailed instructions and definitions were developed and pilot tested in nine grantee sites in the Washington metropolitan area. In addition, contractors have been engaged to provide logistical and technical support for a large demonstration of the data collection followed by eventual programming of the data collection tables to allow the data collection to be done electronically. Following is a discussion of several issues which will impact upon the collection of data to support the cross-cutting indicators developed for the Titles VII and VIII health professions and nursing education and training programs.

Standardized data collection. A study done by the Government Accounting Office on Health Professions Education (GAO/HEHS-94-164, July, 1994) cited the

lack of common outcome goals, data, and reporting requirements to measure progress of these programs. While some of the data required to support the cross-cutting indicators has been collected from grantees in the past, such data has not been collected from all grantees in a standardized format. For example, data regarding the percentage of graduates placed in medically underserved communities is collected for those programs which are subject to a general statutory funding preference (sections 792 and 860 of the PHS Act). These data have not been collected for programs not subject to the preference. Also, most programs have been required to report the number of participants, but the data have not been collected in a manner which will allow aggregation. The CPMS is designed to collect cross-cutting information about Bureau

programs in a standard way so that the outcomes of Bureau programs can be described quantitatively.

Setting Targets and Benchmarks. Setting targets or benchmarks will be essential in the analysis of CPMS data. An external status quo can be used as a comparison for project and/or programs performance. For example, the percentage of minority students in a discipline can be compared to the percentage of minority students in BHPr funded programs.

Officially set program targets could also be used for comparing the performance of individual grantees. Meaningful program targets can only be developed when appropriate baseline data is available. A demonstration study, which will provide "baseline" data, is planned. This demonstration will test the data collection for the CPMS among a statistically valid sample of grantees for all Bureau programs. The request for this data collection has been submitted to OMB for information collection clearance. While these data have not been collected in a standard way across Bureau programs in the past, OMB has provided clearance for collection of many of these data elements for selected Bureau programs in the past. For example, race and ethnicity data is currently collected for participants in many of the Bureau programs. It is expected that the data from the demonstration study will be invaluable in setting performance targets.

Validation of Data. During the demonstration study, the Bureau staff and contractor will obtain the advice of a group of consultants. This group will meet approximately every other month for total of five meetings. It is expected that these consultants will assist the Bureau with identifying methods for validating the data collected.

In addition, a contractor will develop an electronic data collection instrument which will be used to implement the data collection for all grantees following the demonstration study. This contractor will also provide advice to the Bureau regarding validity and reliability of data collected.

Development of Data Base. The Bureau has been working on the development of a database to house outcomes data and other grants related information for the Titles VII and VIII programs. Preliminary data from FY 1996 has been reported in a published report, "Bureau of Health Professions Progress Report: Expanding Access to Care Through Health Professions Education and Training" and in the Bureau Newslink. For example:

- The percentage of graduates entering practice in underserved areas has been documented for some programs. Thirty-three percent of 1995 Family Practice residency graduates of Bureau programs entered practice in Medically Underserved Communities (MUC). Nearly 30 percent of Advanced General Dentistry graduates provided care in MUC's in the past 2 years.

- The percentage of minority graduates in some Bureau programs has been documented. For example, 32 percent of the most recent Physician Assistant graduates of BHPr's programs are from underrepresented minority (URM) backgrounds, while only 17 percent of all PA's are from URM backgrounds.

Program Officer Training. As part of the CPMS development, it is clear that the role of the Program Officer in the Bureau will change. While these staff will continue to be accountable for managing assigned programs, the CPMS will provide data to support program management which have not been available in the past. To assure that Program Officers can maximize the benefit of these new data, a training plan has been developed for Program Officers to include:

- An orientation and overview of GPRA and CPMS (4 hours)

- Intensive CPMS training (2 days)

- Training for the demonstration study (2 days)

- Training for the implementation project

- Training on the use of the data base for the CPMS data

- Report Writer training for development of custom reports from the data base (2 days)

Reauthorization of Program Authority. The Bureau has been seeking reauthorization of the Titles VII and VIII health professions and nursing education and training programs for several years. A reauthorization bill was passed by the Senate in the 104th Congress, but failed in the House. A new bill is expected to be introduced in the Senate early in 1998. To the extent legislation increases flexibility and eligibility for these programs, this will help in allowing the programs to meet the changing needs of the health care system.

HPSA Designation. Health Professions Shortage Areas (HPSA) are included in the system used to measure the percentage of graduates placed in underserved areas. A study done by the GAO (GAO/T-HEHS-97-204, September 11, 1997) cited the HPSA system as being flawed with long-standing weaknesses. The Bureau of Primary Health Care (BPHC), responsible for HPSA designation, and BHPr have been working together to improve the HPSA designation system.

The BHPr and the BPHC will engage in three concurrent activities to: (1) apportion the nation into "rational" service areas for use by States as a Federal "fall-back" position in determining such areas for purposes of the new, proposed Federal shortage area designation; (2) determine which rational service areas could be considered primary care health professions shortage

areas using the new Index of Primary Care Service (IPCS) developed by the BPHC and other measures of "shortage" or unmet need developed in an ongoing BHPr contract with the University of Michigan; and (3) identify the practice locations of the nation's family physicians (FP) and physician assistants (PA) (HPSA/non-HPSA) and determine which of these FPS and PAS have been trained in Title VII sponsored programs. These activities will provide the BPHC with a reliability and validity check of its new IPCS as well as an INITIAL development of national rational service areas. These activities will help BPHr evaluate its FP and PA training programs and their ability to provide practitioners for underserved communities.

PERFORMANCE MEASURES

The Bureau's performance management system includes four cross-cutting goals with respect to workforce quality, supply, diversity and distribution. The major leadership role of the Federal government at this time is in the areas of diversity and distribution of health professionals to assure access to cost-effective, quality health care for vulnerable populations. These priorities are consistent with the GAO report on Titles VII and VIII programs done in 1994 and updated in 1997 (GAO/HEHS-94-164, July, 1994 and GAO/T-HEHS-97-117, April 25, 1997). In these reports, the GAO reviewed Titles VII and VIII programs to determine their effect on (1) increasing the supply of primary care providers and other health professionals, (2) improving their representation in rural and medically underserved areas, and (3) improving minority representation in the health professions. The report of this study concluded that the relationship between these programs and the changes in supply, distribution, and minority representation of health professionals is difficult to establish because the programs have other objectives besides improving supply, distribution, and minority recruitment and because no common outcome goals or measurements have been established. The CPMS provides, for the first time, a cross-cutting set of goals, outcomes and indicators for the Titles VII and VIII programs.

LINK TO STRATEGIC GOALS AND OBJECTIVES

The Health Professions and Nursing education and training programs are supportive of a number of goals in the Department Strategic Plan. In particular, they support:

> Goal 3: Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs, Objective 3: Increase the availability of primary health care services.

In addition, these programs also support:

> Goal 4: Improve the quality of health care and human services, Objective 2: Reduce disparities in the receipt of quality health care services.

These programs are designed to foster a primary care and public health workforce that is qualified, diverse, and appropriately distributed to meet the needs of underserved, vulnerable, and special needs populations. Emphasis is given to promoting the recruitment, training, and retention of minority and

under-represented health professionals and to supporting all health professionals who are helping to improve access to services in rural and inner-city areas.

Several geriatrics programs support:

Goal 2: Improve the economic and social well-being of individuals, families and communities in the United States, Objective 5: Increase opportunities for seniors to have an active and healthy aging experience.

Public Health programs also support:

Goal 5: Improve public health systems, Objective 1: Improve public health systems' capacity to monitor the health status and identify threats to health of the nation's population.

Relative to the HRSA strategic planning process, these programs again primarily support goals/objectives related to geographic distribution and diversity of the health professions including:

Goal 3: Assure Quality of Care: HRSA will assure quality care is provided to the underserved by fostering a diverse, quality workforce and the utilization of emerging technologies.

Goal 1: Eliminate barriers to care: To assure access to comprehensive, timely, culturally competent and appropriate health care services for all underserved, vulnerable, and special needs populations.

REFERENCES

Health Professions Education: Role of Title VII/VIII Programs in Improving Access to Care is Unclear (GAO/HEHS-94-164, July 8, 1994).

Health Professions Education: Clarifying the Role of Title VII and VIII Programs Could Improve Accountability (GAO/T-HEHS-97-117, April 25, 1997).

Health Care Access: Opportunities to Target Programs and Improve Accountability ((GAO/T-HEHS-97-204, September 11, 1997).

Attachment A

Bureau of Health Professions Programs

Health Professions Training for Diversity
- Centers of Excellence in Minority Health (COE)
- Health Careers Opportunity Program (HCOP)
- Faculty Loan Repayment Program (FLRP)/Minority Faculty Fellowships (MFFP)

Student Assistance
- Scholarships for Disadvantaged Students (SDS)
- Exceptional Financial Need Scholarships (EFN)
- Financial Assistance for Disadvantaged Health Professions (FADHPS)
- Loans for Disadvantaged Students

Interdisciplinary, Community-Based Training
- Area Health Education Centers (AHEC)
- Health Education and Training Centers (HETC)
- Rural Health Interdisciplinary Training (IRT)
- Geriatric Programs (GP)
- Allied Health Special Projects (AHSP)
- * Chiropractic Demonstration Projects
- Podiatric Primary Care Residency Training (POD)

Primary Care Medicine and Dentistry
- Family Medicine Training (FM)
- General Internal Medicine/General Pediatrics Training (GIM/GP)
- Physician Assistant Training (PA)
- General Dentistry Training (AGD)

Public Health Workforce Development
- Public Health and Preventive Medicine (PH/PM)
- Health Administration (HA)

* Workforce Information and Analysis

Nursing Education and Practice
- Nursing Special Projects (NSP)
- Advanced Nurse Education (ANE)
- Nurse Practitioner and Nurse-Midwives (NP/NM)
- Professional Nurse Traineeships (PNT)
- Nurse Anesthetist Training (NA)
- Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds (NEO)

* Health Education and Assistance Loans (HEAL)

* National Practitioner Data Bank (NPDB)

* Vaccine Injury Compensation Program (VICP)

*** These programs are not covered by the Comprehensive Performance Management System (CPMS). Program specific performance goals are included in this Annual Performance Plan for these programs**

Attachment B

NATIONAL WORKFORCE GOALS, OUTCOMES, AND INDICATORS

(The Goals are the Roman Numerals; the Outcomes are the ABCs; and the Indicators are the 123s.)

I. Promote a Health Care Workforce with a Mix of the Competencies and Skills Needed to Improve Access to Cost-Effective, Quality Care

A. Prepare an appropriate number of health professionals necessary to provide and support primary care

(1) Number of graduates and/or program completers of primary care tracks by discipline

(2) Number of graduates and/or program completers of health professions programs that support primary care by discipline

B. Increase in program responsiveness to imbalances in the numbers, competency, and skill mix of health professionals

(3) Number of students/trainees in fields where there is an imbalance in competency and/or skill mix

C. Increase in the number of interdisciplinary collaborations

(4) Number of student/trainee clock hours in clinical experiences involving interdisciplinary teams to meet community needs

(5) Number of students/trainees participating in interdisciplinary team experiences

D. Increase in the number of schools/programs with culturally appropriate curricula

(6) Number of student/trainee clock hours in clinical training with health care service delivery organizations that serve predominately minorities

(7) Number of student/trainee clock hours in didactic training which address culturally diverse issues in health care

II. Support Educational Programs' Ability to Meet the Needs of Vulnerable Populations

A. Increase in the number of faculty and trainees in settings serving underserved areas.

(8) Number of faculty clock hours in practices serving underserved areas.

(9) Number of student/trainee clock hours in clinical training with health care service delivery organizations serving underserved areas.

B. Increase in the number of graduates and/or program completers practicing in underserved areas.

(10) Number of graduates entering residencies that serve underserved areas.

(11) Number of graduates and/or program completers who enter practice in underserved areas.

(12) Number of graduates and/or program completers who remain in practice settings serving underserved areas.

III. Improve Cultural Diversity in the Health Professions

A. Increase in the number of minority faculty

(13) Number of underrepresented minorities serving as faculty

B. Increase in the number of minority/disadvantaged graduates and/or program completers

(14) Number of minority/disadvantaged graduates and/or program completers

(15) Number of minority/disadvantaged enrollees

IV. Stimulate and Monitor Relevant Systems of Health Professions Education in Response to Changing Demands of the Health Care Marketplace

A. Increase in the number of schools/programs with active partnerships or cooperative working agreements with public and private community based organizations, such as managed care sites, rural health organizations, community health centers, and others

(16) Number of schools/programs providing training through formal partnerships

B. Increase in continuity of care training experiences

(17) Number of students/trainees participating in community-based continuity of care experiences

Attachment C																	
PROGRAM *	**INDICATORS ****																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
COE													X				
HCOP														X			
FLRP/MFFP													X				
SDS															X		
EFN														X	X		
FADHPS														X	X		
LDS														X	X		
AHEC									X								X
HETC									X					X	X		
I RT					X										X		X
GP		X	X										X				
AHSP			X								X						
POD	X													X			
FM	X										X						
GIM/GP	X										X						
PA	X										X			X			
AGD	X										X			X			
PH/PM														X		X	
HA											X						
NSP																	X
ANE	X	X									X				X		
NP/NM	X														X		
PNT											X				X		
NA											X						
NEO															X		

* please see Attachment A for program title acronyms

** please see Attachment B for the indicators associated with these numbers

Annual Performance Plan: FY 1999 Budget
Health Professions Training for Diversity

Program Activity: Centers of Excellence in Minority Health

Description of Program Activity: This program addresses the goal of diversity and distribution of minorities in the workforce. Grants are made to selected schools of medicine, osteopathic medicine, dentistry, and pharmacy that train a significant number of minority individuals to establish and maintain Centers of Excellence in Minority Health. Activities of these centers include student recruitment and enhancement of academic performance; faculty recruitment, training and retention; improvement of information resources, curricula, and clinical education; and faculty and student research.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Increase the number of minority researchers and the quality of research related to minority health issues by involving at least 400 students in research activities directly related to minority health issues which result in the publication of at least 25 studies each year.

   Indicator:
   (Program specific indicator) The number of students involved in research activities directly related to minority health issues. The number of studies published as a result of student research.

B. Increase the number of permanent full-time minority faculty by at least 40.

   Indicator:
   (Program specific indicator) The number of permanent full-time minority faculty.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on diversity in the health professions.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Centers of Excellence	$24,798	$0	$24,798

Annual Performance Plan: FY 1999 Budget

Program Activity: **Health Careers Opportunity Program**

Description of Program Activity: The goal of this program is to increase the number and improve the academic preparation of individuals from disadvantaged backgrounds to enter health and allied health professions careers. The program works to build diversity in the health fields by supporting students from disadvantaged backgrounds and allowing them to enhance their academic skills to successfully compete, enter, and graduate from health professions programs. Medical schools participating in HCOP have accepted underrepresented applicants at a rate more than 20 percent above the national average during the past five years. Grants are awarded to schools of medicine, osteopathic medicine, public health, dentistry, veterinary medicine, optometry, pharmacy, podiatric medicine, allied health, chiropractic, and public or nonprofit private schools which offer graduate programs in clinical psychology, social work and other public or private non-profit health or educational entities. Activities include recruitment, preliminary education, facilitating entry, retention, and financial aid information dissemination.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Maintain the number of students in structured programs at 5,400.

   Indicator: (Program specific indicator) The number of students in structured programs.

B. Graduate at least 1,120 underrepresented minority/disadvantaged students from grantee health professions programs.

   Indicator: (Cross-cutting indicator) Number of minority/disadvantaged graduates and/or program completers.

C. Increase the average MCAT score of HCOP participants to 9.9 (average score of non-minority applicants to medical schools) from 8.25 (average score of minority applicants to medical schools).

   Indicator: (Program specific indicator) The average MCAT score of HCOP participants.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on diversity in the health professions.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
HCOP	$26,870	$0	$26,870

Annual Performance Plan: FY 1999 Budget

Program Activity: **Faculty Loan Repayment Program/Minority Faculty Fellowships**

Description of Program Activity: The goal of this program is to improve the diversity of faculty in health professions schools. This program is one of the major Federal efforts in support of disadvantaged/underrepresented minority health professions schools and the only program of its type. Faculty Loan Repayment contracts repay a portion of the educational loans of individuals from disadvantaged backgrounds who agree to serve as faculty members in accredited schools of medicine, nursing, osteopathic medicine, dentistry, pharmacy, podiatric medicine, optometry, veterinary medicine, or public health, or schools offering graduate programs in clinical psychology. Minority Faculty Fellowships are awards to health professions schools for fellowships and related activities to increase the number of underrepresented minority faculty members in schools of medicine, optometry, podiatric medicine, pharmacy, public health, health administration, clinical psychology, and other public or private nonprofit health or educational entities.

Annual Performance Goals and Performance Indicators:

Performance Goal

A. Increase the number of disadvantaged/underrepresented minority faculty members in health professions schools by providing loan repayment or fellowship funding for 32 new faculty.

   Indicator:
   (Program specific indicator) The number of disadvantaged/underrepresented minority faculty members participating in Faculty Loan Repayment or Minority Faculty Fellowship Programs.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on diversity in the health professions.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Faculty Loan Repayment/ Minority Faculty Fellowship	$1,065	$0	$1,065

Annual Performance Plan: FY 1999 Budget
Student Assistance

Program Activity: **Scholarships for Disadvantaged Students**

Description of Program Activity: The goal of this program is to improve the diversity of health professions students and practitioners as well as improve their distribution in the workforce. Disadvantaged health care providers are more likely to begin practice and remain in areas where access to quality health care and related support services are limited, as well as to provide care to those who are underserved, disadvantaged, or have special needs. Awards are made to accredited schools of allopathic medicine, osteopathic medicine, dentistry, optometry, pharmacy, podiatric medicine, veterinary medicine, nursing, public health or allied health, or schools offering graduate programs in clinical psychology for the purpose of providing scholarships to financially needy students from disadvantaged backgrounds who are enrolled or accepted for enrollment as full-time health professions students.

Annual Performance Goals and Performance Indicators:

Performance Goal

A. 3,750 graduates will enter practice in underserved areas.

Indicator:
(Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on diversity in the health professions.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Scholarships for Disadvantaged Students	$18,737	$0	$18,737

Annual Performance Plan: FY 1999 Budget

Program Activity: **Exceptional Financial Need Scholarships**

Description of Program Activity: The goal of this program is to increase the supply of primary care providers as well as to increase the diversity of students and practitioners. Awards are made to schools to provide financial assistance to full-time students of exceptional financial need pursuing a degree in medicine, dentistry, or osteopathic medicine. Students of medicine and osteopathic medicine must agree to (a) enter and complete residency training in primary care, and (b) practice in primary care for 5 years after completing residency training program. Students of dentistry must agree to practice in general dentistry for 5 years after completing residency training. These individuals do not have access to scholarships from any other source.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Maintain 33 percent enrollment of underrepresented minority students.

Indicator:
(Cross-cutting indicator) The number of minority/disadvantaged enrollees.

B. Facilitate education of 50 underrepresented minority graduating students.

Indicator:
(Cross-cutting indicator) The number of minority/disadvantaged graduates and/or program completers.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on diversity in the health professions.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Exceptional Financial Need Scholarships	$11,371	$0	$11,371

Annual Performance Plan: FY 1999 Budget

Program Activity: **Financial Assistance for Disadvantaged Health Professions Students**

Description of Program Activity: The goal of this program is to increase the supply of primary care providers and to increase the diversity of students and practitioners. Awards are made to schools for the purpose of providing tuition scholarships to students from disadvantaged backgrounds who are of exceptional financial need and are pursuing a degree in allopathic medicine, osteopathic medicine, or dentistry. Students of medicine and osteopathic medicine must agree to (a) enter and complete residency training in primary care, and (b) practice in primary care for 5 years after completing residency training programs. Students of dentistry must agree to practice in general dentistry for 5 ears after completing residency training. Over 40 percent of these scholarship recipients are underrepresented minorities.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Maintain 40 percent participation of underrepresented minority students.

Indicator:
(Cross-cutting indicator) The number of minority/disadvantaged enrollees.

B. Facilitate education of 36 underrepresented minority graduates annually.

Indicator:
(Cross-cutting indicator) The number of minority/disadvantaged graduates and/or program completers.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on diversity in the health professions.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Financial Assistance for Disadvantaged Health Professions Students	$6,741	$0	$6,741

Annual Performance Plan: FY 1999 Budget

Program Activity: **Loans for Disadvantaged Students**

Description of Program Activity: The goal of this program is to increase diversity in the workforce and improve the distribution of practitioners. Funds are provided to eligible health professions schools for the purpose of providing long-term, low-interest loans to eligible individuals from disadvantaged backgrounds who are enrolled or accepted for enrollment as full-time students pursuing a career in allopathic medicine, osteopathic medicine, dentistry, optometry, podiatric medicine, pharmacy or veterinary medicine. Special consideration is given to health professions schools that have enrollments of underrepresented minorities above the national average for health professions schools. Disadvantaged health care providers are more likely to enter practice and remain in areas where access to quality health care and related support services are limited, and to provide care to those who are underserved, disadvantaged, or have special needs.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Maintain 50 percent participation of underrepresented minority students.

   Indicator:
   (Cross-cutting indicator) The number of minority/disadvantaged enrollees.

B. Graduate 375 underrepresented minority students.

   Indicator:
   (Cross-cutting indicator) The number of minority/disadvantaged graduates and/or program completers.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on diversity in the health professions.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Loans for Disadvantaged Students	$0 (Revolving Fund)	$0	$0

Annual Performance Plan: FY 1999 Budget
Interdisciplinary, Community-Based Training

Program Activity: **Area Health Education Centers**

Description of Program Activity: The goal of this program is to improve the distribution of health professionals and increase the proportion that are in primary care. The program addresses the goal of graduating 50 percent of medical students who select a primary care specialty, and increasing the number of health professions graduates who ultimately practice in underserved areas. Multidisciplinary teams of students, faculty and practitioners are trained in community health centers, health departments and other remote and underserved areas. Cooperative agreements are awarded to assist schools to improve the distribution, supply, quality, utilization, and efficiency of health personnel in the health services delivery system, by encouraging the regionalization of educational responsibilities of health professions schools. By linking the academic resources of the university health science center with local planning, educational and clinical resources, the AHEC program establishes a network of health-related institutions to provide educational services to students, faculty, and practitioners, and ultimately to improve delivery of health care.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Train at least 10,000 health professions students in community-based ambulatory care sites in rural/underserved areas.

   Indicator:
   (Program specific indicator) The number of health professions students trained in community-based ambulatory care sites in rural/underserved areas.

B. Establish AHEC program training linkages with 200 CHCs/MHCs.

   Indicator:
   (Program specific indicator) The number of AHEC program training linkages with CHCs/MHCs.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
AHEC	$28,587	$0	$28,587

Annual Performance Plan: FY 1999 Budget

Program Activity: **Health Education and Training Centers**

Description of Program Activity: The goal of this program is to improve the distribution of health professionals along the U.S./Mexico border and in the State of Florida. This program provides training experiences for health professions students and local providers at sites of severe underservice in order to improve the distribution, diversity and cultural competence of the health workforce. The population served by the HETC projects are racially/ethnically, culturally and linguistically diverse. Grant support is provided to schools of allopathic or osteopathic medicine for the purpose of planning, developing, establishing, maintaining, and operating health education and training centers.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Provide a 4 to 8 week public health training experience for 250 health professions students at underserved sites.

   Indicator:
   (Program specific indicator) The number of health professions students who receive a 4 to 8 week public health training experience in an underserved site.

B. Provide a health career training experience for 250 minority or rural disadvantaged students.

   Indicator: (Program specific indicator) The number of minority or ruraldisadvantaged students who receive a health career training experience.

In addition, work will progress on the Bureau’s comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
HETC	$3,765	$0	$3,765

Annual Performance Plan: FY 1999 Budget

Program Activity: **Rural Health Interdisciplinary Training**

Description of Program Activity: The goal of this program is to improve the distribution of health professionals by increasing the number in rural areas. This program is the only Federal program designed to recruit, train and retain teams of interdisciplinary professionals to work in rural underserved areas. Grants are awarded for the purpose of providing support for the education and training of health care professionals to encourage and prepare them to enter into and/or remain in practice in rural America where health care professionals are currently in short supply. These projects demonstrate innovation in the interdisciplinary training of health care practitioners and are designed to establish long-term collaborative relationships between academic institutions, rural health care agencies and health care providers in rural areas to contribute to the goals of recruiting and retaining practitioners for rural areas. The current retention rate is 75 percent.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Train 350 students in community settings in utilization of interdisciplinary teams.

   Indicator:
   (Cross-cutting indicator) The number of student/trainees participating in interdisciplinary team experiences.

B. Train 950 rural health care providers in community settings in utilization of interdisciplinary teams.

   Indicator:
   (Cross-cutting indicator) The number of student/trainees participating in interdisciplinary team experiences.

C. Develop 20 community-based interdisciplinary clinical training sites.

   Indicator:
   Program specific indicator) The number of community based interdisciplinary clinical training sites developed.

D. Place 50 percent of graduates in rural or frontier areas.

   (Cross-cutting indicator) The number of graduates and/or program completers who enter practice in underserved areas.

In addition, work will progress on the Bureau’s comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Rural Health Interdisciplinary Training	$4,167	$0	$4,167

Annual Performance Plan: FY 1999 Budget

Program Activity: **Geriatric Programs**

Description of Program Activity: The goal of the geriatric programs is to increase the supply of geriatric faculty and to improve the distribution and increase the supply of geriatric trained practitioners. These projects provide the sole interdisciplinary geriatric faculty fellowships in the country. The also provide the only geriatric fellowships available to dentists. The goal is to establish a Geriatric Education Center (GEC) in each state with elderly populations over 12.5 percent. GECs are the only national network for geriatric education. The ultimate purpose is to prepare all health care providers to serve older adults. With the influx of 56 million baby boomers, the geriatric specialties alone will not be able to provide the range of services needed. GEC grants are awarded to eligible health professions schools to strengthen multidisciplinary training of health professionals in the diagnosis, treatment, and prevention of disease and other health concerns of the elderly. Within a defined geographic area, services are provided and collaborative relationships are fostered among members of the health professions education community. Fellowship grants are awarded to public or private nonprofit schools of medicine, schools of osteopathic medicine, teaching hospitals or graduate medical education programs for faculty training projects in geriatric medicine and dentistry. These projects emphasize the principles of primary care as demonstrated through continuity of care, ambulatory, preventive and psychosocial aspects of the practice of geriatric medicine, geriatric psychiatry, and geriatric dentistry.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Train 52 faculty fellows in geriatric medicine, dentistry and psychiatry.

   Indicator:
   (Cross-cutting indicator) The number of graduates and/or program completers of health professions programs that support primary care by discipline.

B. Leverage $3 for every $1 of Federal support for GECs.
   Indicator:

   (Program specific indicator) The amount of funds leveraged by Federal dollars used to support GECs.

C. Train 20,000 health care providers in geriatric principles.

   Indicator:
   (Cross-cutting indicator) The number of students/trainees in fields where there is an imbalance in competency and/or skill mix (geriatrics).

D. Recruit and train a minimum of 10 new minority faculty for the GEC network.

   Indicator:

(Cross-cutting indicator) The number of underrepresented minorities serving as faculty.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the

extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Geriatric Programs	$8,911	$0	$8,911

Annual Performance Plan: FY 1999 Budget

Program Activity: **Allied Health Special Projects**

Description of Program Activity: The goal of this program is to increase the supply and distribution of allied health practitioners. Sixty percent of the entire health care workforce are allied health personnel. The number of new entrants required to replace deaths and retirements and account for increased demands for the allied health practitioners will increase by 43 percent over the next 5 to 10 years. Grants are awarded to eligible schools, universities or other public or nonprofit private educational entities to assist in meeting the costs associated with expanding or establishing programs that will increase the number of individuals trained in allied health professions.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Support 3,100 allied health graduates in 32 different disciplines.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers of health professions programs that support primary care by discipline.

B. Increase from 26 (1997 Baseline) to 33 percent the number of allied health graduates entering practice in rural or urban underserved areas.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Allied Health	$3,845	$0	$3,845

Annual Performance Plan: FY 1999 Budget

Program Activity: **Chiropractic Demonstration Projects**

Description of Program Activity: The goal of this program is to increase the chiropractic research base for treatment of low back pain by linking Schools of Chiropractic and Schools of Medicine in joint research projects. This is the only Federally-funded chiropractic research program in the country. The program also seeks to increase the number of chiropractic researchers and assist schools in developing research infrastructures and productive clinical research programs. This program is also increasing the knowledge base of the existing 50,000 chiropractors. Federal funds have promoted the clinical advancement of more than 300 practitioners to date. Under this program, chiropractors have provided care to more than 6,000 patients with spinal and lower-back conditions. Grants are awarded to public or private nonprofit schools, colleges, and universities of chiropractic to carry out demonstration projects in which chiropractors and physicians collaborate to identify and provide effective treatment for spinal and lower-back conditions.

Annual Performance Goals and Performance Indicators:

Performance Goal

A. Support 16 full-time chiropractic researchers involved in joint projects in which chiropractors and physicians collaborate to identify and provide effective treatment for spinal and lower-back conditions.

   Indicator:
   (Program specific indicator) The number of full-time chiropractic researchers involved in joint projects.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Chiropractic Demon.	$1,029	$0	$1,029

Annual Performance Plan: FY 1999 Budget

Program Activity: **Podiatric Primary Care Residency Training**

Description of Program Activity: The goal of this program is to increase the supply of podiatrists and improve their diversity and distribution. Grants are awarded to public or nonprofit private hospitals or accredited schools of podiatric medicine to assist with the costs of training podiatric physicians who plan to specialize in primary care. This is the only Federal program that addresses this need.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Increase the number of podiatrists entering primary care practice by 27.

   Indicator:
   (Cross-cutting indicator) The number of graduates and/or program completers of primary care tracks by discipline.

B. Increase the percentage of trained underrepresented minority or disadvantaged podiatric primary care physicians from 14 to 15 percent.

   Indicator:
   (Cross-cutting indicator) The number of minority/disadvantaged graduates and/or program completers.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Podiatric Medicine	$679	$0	$679

Annual Performance Plan: FY 1999 Budget
Primary Care Medicine and Dentistry

Program Activity: **Family Medicine Training**

Description of Program Activity: The goal of Family Medicine programs is to increase the supply of primary care practitioners and to improve their distribution and diversity. Title VII is the only source of funds available to support graduate medical education for the purpose of increasing diversity and preparing physicians to serve in medically underserved areas. The program accomplishes this goal through faculty development, establishment of Family Medicine departments, and requiring third year clerkships in Family Medicine. The program has been a successful instrument in leveraging the health professions training system capacity and orientation toward primary care. The Title VII supported family medicine programs produce a greater percentage of family physicians who locate in rural and underserved areas than family medicine training programs that do not receive such funding. Grants are awarded to accredited allopathic or osteopathic medical schools, hospitals or other public or private nonprofit entities which provide health or educational programs as a major function. Funds are used to plan and develop model predoctoral, graduate medical education and faculty development programs in family medicine and to support the establishment of departments of family medicine.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Provide training for 350 faculty in family medicine.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers of primary care tracks by discipline (faculty development).

B. Increase the percentage of graduates of medical school practicing in primary care from 35 percent to 40 percent (6,000 graduates to 7,000 graduates).

   Indicator:
   (Program specific indicator) The number of medical school graduates practicing in primary care.

C. 600 family residents will enter practice in medically underserved areas.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

D. Increase the percentage of minority family physicians from 10 percent to 12 percent.

Indicator:
(Program specific indicator) Percentage of minority family physicians.

In addition, work will progress on the Bureau’s comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Family Medicine Programs	$49,424	$0	$49,424

Annual Performance Plan: FY 1999 Budget

Program Activity: **General Internal Medicine/General Pediatrics Training**

Description of Program Activity: The goal is these programs is to increase the supply, and improve the distribution and diversity of general internist and general pediatricians. This is accomplished by supporting residency training in the primary care tracks of internal medicine and pediatrics. This program has leveraged the health professions training system capacity and orientation toward primary care. More than 88 percent of graduates of Title VII programs are practicing in primary care, a rate nearly twice that of programs not receiving Title VII funds. Grants are made to accredited allopathic or osteopathic medical schools, hospitals or other public or private nonprofit entities which provide health or educational programs as a major function. Funds are used to plan, develop, and operate or participate in approved residency training programs which will emphasize the training of residents for the practice of general internal medicine or general pediatrics or to meet the cost of planning, developing, and operating programs for the training of physicians who plan to teach in general internal medicine and general pediatrics training programs.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Produce 500 residents who complete general internal medicine or general pediatric residencies.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers of primary care tracks by discipline.

B. 300 residents in general internal medicine and general pediatrics will enter practice in underserved areas.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

C. Increase from 5 percent to 8 percent the number of minority faculty in academic Divisions or Sections of General Internal Medicine or General Pediatrics.

   Indicator:
   (Program specific indicator) The percentage of minority faculty in academic Division or Sections of General Internal Medicine or General Pediatrics.

In addition, work will progress on the Bureau’s comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
General Internal Medicine/General Pediatrics	$17,678	$0	$17,678

Annual Performance Plan: FY 1999 Budget

Program Activity: **Physician Assistant Training**

Description of Program Activity: The goal of this program is to increase the supply of physician assistants and improve their diversity and distribution. The program accomplishes its goals through faculty and site development and support of programs and students. These funded programs have a track record of producing PAS that are more diverse and more likely to serve the underserved than graduates of non-funded programs. Title VII funding has served to increase PA practice in rural areas by 40 percent over the past four years. Grants are awarded to accredited physician assistant programs for projects (1) for the training of physician assistants and (2) for the training of individuals who will teach in programs of such training. Programs assisted are primary care oriented and stress educational experiences and practice location in health professional shortage areas.

Annual Performance Goals and Performance Indicators:

Performance Goals:

A. 1,350 PAS will graduate.

Indicator:
(Cross-cutting indicator) Number of graduates and/or program completers of primary care tracks by discipline.

B. 650 PA graduates will be underrepresented minorities.

Indicator:
(Cross-cutting indicator) Number of minority/disadvantaged graduates and/or program completers.

C. 700 PA graduates will enter practice in medically underserved areas.

Indicators:
(Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Physician Assistant Training	$6,398	$0	$6,398

Annual Performance Plan: FY 1999 Budget

Program Activity: **General Dentistry Training**

Description of Program Activity: The goal of this program is to increase the number and improve the distribution of general dentists with advanced post doctoral training. This program has a proven track record of producing graduates who are more likely to practice in underserved areas and who are more diverse than dentists not supported by this program. No other entity supports the advanced education of general dentists. The Federal support of these programs serves as a catalyst; 88 percent of the programs supported in the past are still in existence after the Federal funding has been withdrawn. Grants are awarded to accredited public or nonprofit private schools of dentistry or accredited postgraduate dental training institutions for postgraduate programs of residency training and advanced education in general dentistry to increase the number of training opportunities in advanced general dentistry and to improve program quality.

Annual Performance Goals and Performance Indicators:

Performance Goals:

A. A minimum of 30 percent of graduates from this program will be placed in practice settings in underserved areas.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

B. A minimum of 30 percent of graduates from this program will be minorities.

   Indicator:
   (Cross-cutting indicator) Number of minority/disadvantaged graduates and/or program completers.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
General Dentistry Training	$3,798	$0	$3,798

Annual Performance Plan: FY 1999 Budget
Public Health Workforce Development

Program Activity: **Public Health and Preventive Medicine**

Description of Program Activity: The goal of this program is to increase the supply of public health professionals, preventive medicine specialists, and public health dentists and to improve their diversity in the public health and preventive medicine workforce. This goal is accomplished by preparing the current and future public health workforce for community-oriented public health practice in a rapidly changing health care system. This preparation is achieved by increasing the number of state and local public health providers who receive continuing education, initiating academic and community partnership coalitions for basic and continuing education, providing support to preventive medicine residents including underrepresented minorities, and supporting public health dentists including underrepresented minorities. Grants are awarded to (1) accredited schools of public health and other public or nonprofit private institutions accredited for the provisions of graduate or specialized training in public health for the provision of graduate training to individuals pursuing a course of study in a health professions field in which there is a severe shortage of health professionals (epidemiology, environmental health, biostatistics, toxicology, public health nutrition and maternal and child health), (2) accredited schools of public health for the costs of planning, developing, demonstrating, operating, and evaluating projects that will further the goals established in “Healthy People 2000" objectives in the areas of preventive medicine, health promotion and disease prevention, improving access to and quality of health services in medically underserved communities, or reducing the incidence of domestic violence, (3) to accredited public or non-profit private schools of allopathic medicine, osteopathic medicine, or public health to help schools promote the graduate medical education of physicians in preventive medicine and to advance the cause of health promotion and disease prevention, and (4) to dental public health residency programs accredited by the Commission on Dental Accreditation to assist schools in planning and developing new residency training programs, maintaining or improving existing residency training programs in dental public health and providing financial assistance to residency trainees enrolled in such programs.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Support 1,500 public health traineeships which will produce 750 graduates.

   Indicator:
   (Program specific indicator) Number of public health traineeships supported.

B. Support 30 preventive medicine residents and 11 dental public health residents.

Indicator:
(Program specific indicator) Number of preventive medicine and dental public health residents supported.

C. Maintain 35 percent minority graduates.

Indicator:
(Cross-cutting indicator) Number of minority/disadvantaged graduates and/or program completers.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Public Health/ Preventive Medicine	$8,025	$0	$8,025

Annual Performance Plan: FY 1999 Budget

Program Activity: **Health Administration**

Description of Program Activity: The goal of this program is to increase the supply and improve distribution of health administrators. This goal is accomplished by equipping health administrators with skills to manage new and emerging delivery systems by supporting trainees and promoting curriculum change and by providing training in underserved locations, including public health agencies and community/migrant health centers. Grants are awarded to accredited graduate degree programs in health administration, hospital administration, or health policy analysis and planning for the purpose of providing traineeship support and to support special projects to assist educational institutions in the development or improvement of programs which prepare graduate students for employment with public or nonprofit private agencies and organizations. Grantees must meet all of the following condition: (1) not less than 25 percent of the graduates of the applicant are engaged in full-time practice settings in medically underserved communities, (2) the applicant recruits and admits students from medically underserved communities, (3) for the purpose of training students, the applicant has established relationships with public and nonprofit providers of health care in the community involved, and (4) in training students, the applicant emphasizes employment with public or nonprofit private entities.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Support 2,800 health administration students which will produce 600 graduates.

   Indicator:
   (Program specific indicator) Number of health administration students supported.

B. 350 graduates will take positions in underserved areas.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Health Administration	$1,099	$0	$1,099

Annual Performance Plan: FY 1999 Budget
Workforce Information and Analysis

Program Activity: **Workforce Information and Analysis**

Description of Program Activity: Provides leadership for ongoing monitoring and surveillance of the workforce environment through contracts and cooperative agreements. This program is the foundation of a National Center for Health Workforce Information and Analysis, a repository of current and future information about the status of the health professions. In FY 1998, this program will support a limited number of national policy analyses, one center for health professions education research, two Sentinel State Networks in health workforce distribution, technical assistance to the States in workforce monitoring and surveillance, and the maintenance of county level and health professional databases.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Publish the results of 4 data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce.

   Indicator:
   (Program specific indicator) The number of publications that describe the results of data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce.

B. Provide technical assistance to 10 additional states in use of the national integrated models for estimating supply and requirements of generalist health professionals and the spectrum of medical specialization. (Baseline: technical assistance has been provided to date to 20 States.)

   Indicator:
   (Program specific indicator) The number of states which received technical assistance in the use of the national integrated models for estimating supply and requirements of generalist health professionals and the spectrum of medical specialization.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Workforce Analysis	$689	$0	$689

Annual Performance Plan: FY 1999 Budget
Nursing Education and Practice

Program Activity: **Nursing Special Projects**

Description of Program Activity: The goal of this program is to increase the supply of baccalaureate trained nurses and improve the distribution of RNs by providing care experiences in noninstitutional settings in medically underserved communities (nurse managed clinics). The current and emerging health care system requires a nurse workforce whose education prepares it to function across sectors and provide nursing services to individuals, families, groups and populations. To meet this need will require a change in the educational mix toward increasing the number of nurses prepared at the baccalaureate level. In addition, this program prepares nurses to provide affordable, cost-effective health care in underserved areas.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Support the enrollment of 2,300 students in baccalaureate programs.

   Indicator:
   (Program specific indicator) The number of students supported in baccalaureate nursing programs.

B. Provide at least 130,000 primary care visits in nurse managed clinics in underserved areas.

   Indicator:
   (Program specific indicator) The number of primary care visits in nurse managed clinics.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Nursing Special Projects	$10,600	$0	$10,600

Annual Performance Plan: FY 1999 Budget

Program Activity: **Advanced Nurse Education**

Description of Program Activity: The goals of this program is to increase the supply of nurses with advanced degrees. This is accomplished through faculty development, establishment of training sites, and student support. Grants are awarded to collegiate schools of nursing to meet the costs of projects to plan, develop and operate, or significantly expand programs at the master's or doctoral level to prepare advanced practice nurses, nurse educators, and public health nurses. Nurses with graduate preparation are needed to work with specialty care populations, as nurse educators, public health nurses and clinical nurse specialists in all settings, especially underserved areas. Also, this program is administered to provide an incentive (funding priority) for enrollment of individuals from minority backgrounds.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Graduate at least 400 nurses with preparation as advanced practice nurses.
   Indicator: (Cross-cutting indicator) Number of graduates and/or program completers of primary care tracks by discipline or number of graduates and/or program completers of health professions programs that support primary care by discipline.

B. Achieve a 14 percent minority enrollment level.
   Indicator:
   (Cross-cutting indicator) Number of minority/disadvantaged enrollees.

C. Achieve a level 30 percent of graduates placed in medically underserved settings.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Advanced Nurse Education	$12,510	$0	$12,510

Annual Performance Plan: FY 1999 Budget

Program Activity: **Nurse Practitioner and Nurse-Midwives**

Description of Program Activity: The goal of this program is to increase the supply of nurse practitioners and nurse-midwives. Grants are awarded to eligible applicants to plan, develop and operate, significantly expand, or maintain programs for the education of nurse practitioners and nurse-midwives so they will be qualified to effectively provide primary health care in settings such as homes, ambulatory care facilities and other health care institutions particularly in underserved areas. Also, this program is administered to provide an incentive (funding priority) for enrollment of individuals from minority backgrounds.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Graduate at least 500 nurses, NPs or NMWs, who are prepared to provide primary care to individuals and families.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers of primary care tracks by discipline.

B. Achieve a 14 percent minority enrollment level.

   Indicator:
   (Cross-cutting indicator) Number of minority/disadvantaged enrollees.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Nurse Practitioner/ Nurse-Midwife	$17,646	$0	$17,646

Annual Performance Plan: FY 1999 Budget

Program Activity: **Professional Nurse Traineeships**

Description of Program Activity: The goal of this program is to improve the supply, diversity, and distribution of RNs by providing financial assistance to RN students enrolled in graduate nursing education including RNs prepared as advanced practice nurses who come from minority backgrounds. Grants are awarded to public and nonprofit private entities providing master's and doctoral degree programs (or in certain certification nurse-midwifery programs) to educate individuals to serve in and prepare for practice as nurse practitioners, nurse- midwives, nurse educators, public health nurses, or in other clinical nursing specialties determined by the Secretary to require advanced education.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Place 40 percent of the graduates of this program in underserved areas.

Indicator:
(Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

B. Increase the enrollment of minority students from 4 percent to 5 percent.

Indicator:
(Cross-cutting indicator) Number of minority/disadvantaged enrollees.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Professional Nurse Traineeships	$15,995	$0	$15,995

Annual Performance Plan: FY 1999 Budget

Program Activity: **Nurse Anesthetist Training**

Description of Program Activity: The goal of this program is to improve the supply and distribution of nurse anesthetists by increasing the number in rural areas. Grants are awarded to eligible public and private nonprofit institutions to cover the costs of traineeships for licensed registered nurses to become nurse anesthetists, to meet the costs of projects to develop and operate, or maintain or expand programs designed to qualify registered nurses to become certified registered nurse anesthetists, or to provide individual fellowships to CRNA faculty members who have been approved for support.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Graduate 1,000 nurse anesthetists.

   Indicator:
   (Program specific indicator) Number of second year nurse anesthetist students supported.

B. Place 30 percent of the nurse anesthetist graduates in practice settings in underserved/rural areas.

   Indicator:
   (Cross-cutting indicator) Number of graduates and/or program completers who enter practice in underserved areas.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Nurse Anesthetist Training	$2,774	$0	$2,774

Annual Performance Plan: FY 1999 Budget

Program Activity: **Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds**

Description of Program Activity: The goal of this program is to improve the diversity of the nursing workforce. A diverse nursing workforce is essential to meeting the increasing needs of the population for culturally sensitive and appropriate health care. The program also contributes to the basic preparation of minority nurses for leadership positions. Grants are awarded to eligible applicants to meet the costs of special projects to increase nursing education opportunities for individuals from disadvantaged backgrounds by (1) identifying, recruiting, and selecting such individuals, (2) facilitating the entry of such individuals into schools of nursing, (3) providing counseling or other services designed to assist such individuals to complete their nursing education, (4) providing preliminary education designed to assist them to complete successfully such regular course of education, (5) paying such stipends as the Secretary may determine for such individuals, (6) publicizing existing sources of financial aid available to persons enrolled in schools of nursing and (7) providing training, information, or advice to the faculty of such schools with respect to encouraging such individuals to complete the programs of nursing education.

Annual Performance Goals and Performance Indicators:

Performance Goal

A. Maintain 35 percent minority enrollment in grant-supported schools.

Indicator:
(Cross-cutting indicator) Number of minority/disadvantaged enrollees.

In addition, work will progress on the Bureau's comprehensive performance monitoring system, which includes efforts to improve overall data on the extent to which programs support an expanded ability to meet the needs of vulnerable populations, to improve diversity in the health professions, and to respond to the changing demands of the health care marketplace.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds	$3,878	$0	$3,878

Annual Performance Plan: FY 1999 Budget

Program Activity: **Health Education and Assistance Loans (HEAL)**

Description of Program Activity: The goal of the HEAL program has been to maintain socioeconomic diversity in the workforce at minimum cost to taxpayers and borrowers. The program insured market-rate loans by non-Federal lenders to graduate students attending health professions schools.

It is proposed to provide no new loan insurance in FY 1999. The program is proposed to be phased out, a pattern it has been in for the past few years. Borrowers have paid an insurance premium of 6 or 8 percent of the amount borrowed at the time the loan is disbursed. Loan repayment begins the first day of the 10th month after the borrower ceases to be a full-time student at a HEAL school, except that repayment may be deferred for certain purposes specified in the law.

Annual Performance Goals and Performance Indicators:

Performance Goal

A. Conduct an orderly phase out of the loan insurance authority.

Indicator:
The loan insurance program is phased out with a minimum of disruption for the existing student accounts.

Data Collection and Validation:

Data on each HEAL loan are provided by HEAL lenders as a program requirement for loan insurance to be in effect. Data are readily available from loan applications submitted to lenders by student borrowers. Loan amount need is certified by the borrower's school, and data are considered reliable. No alternatives are being considered.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
Loan Guarantee Auth (non-add)	$(85,000)	$(-85,000)	0
Liquidating Account (non-add)	(29,566)	(7,434)	(37,000)
Program Account	1,020	-1,020	0
Credit Reform -Direct Operations	2,688	1,000	3,688

Annual Performance Plan: FY 1999 Budget

Program Activity: **National Practitioner Data Bank**

Description of Program Activity: Provides an alert or flagging system whose principal purpose is to facilitate a more comprehensive review of professional credentials. The Data Bank collects and releases to eligible parties the following information relating to professional competence and professional conduct of physicians, dentists, and in some cases, other licensed health care practitioners: (a) medical malpractice payments resulting from a written claim or judgment: (b) adverse licensure actions taken by state medical and dental boards; (c) professional review actions taken by hospitals and other health care entities that adversely affect clinical privileges; (d) professional review actions taken by professional societies which adversely affect society memberships. Access to Data Bank information is restricted by Federal regulation to eligible entities and practitioners.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Increase the number of Federal agencies with access to core credentialing data on Federal practitioners.

   Indicator:
   (Program specific indicator) The number of other Federal agencies to which access NPDB core credentialing data.

B. Improve the quality of information in the NPDB by linking it with information from other existing data bases.

   Indicator:
   (Program specific indicator) The number of other existing data bases which are linked to the NPDB.

Data Collection and Validation:

Data regarding other Federal agencies to which the NPDB offers services and regarding other existing data bases which are linked to the NPDB will be identified from formal agreements with the NPDB and other administrative records.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
NPDB	$(8,000)	$(+4,000)	$(12,000)
User Fees (non-add)			

Annual Performance Plan: FY 1999 Budget

Program Activity: **Vaccine Injury Compensation Program (VICP)**

Description of Program Activity: A no-fault alternative to the tort system for resolving claims resulting from adverse reactions to covered vaccines. The VICP is administered jointly by the United States Court of Federal Claims, the Department of Health and Human Services, and the Department of Justice. A petitioner can qualify for compensation by proving that: (1) the vaccine caused the injury, or (2) an injury listed on the Vaccine Injury Table, as set forth in the Act, occurred within the specified time periods.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. Lawsuits filed against DTP manufacturers will be reduced by at least 80 percent below (to 52 filings or less) the number of lawsuits filed in 1986, the year of VICP enactment.

   Indicator:
   Number of lawsuits filed against DTP manufacturers.

B. Investigational New Drug (IND) submissions to the Food and Drug Administration will increase by at least 20 percent (to 35 INDs or more) over the level of IND submissions in 1986, the year of VICP enactment.

   Indicator:
   Number of Investigational New Drug (IND) submissions to the Food and Drug Administration.

C. Process payment of 90 percent of annuities within 60 calendar days of receipt of a Department of Justice (DOJ) clearance letter.

   Indicator:
   Percent of annuities processed within 60 calendar days of receipt of a DOJ clearance letter.

D. Process payment of 90 percent of lump sum awards within 30 calendar days of receipt of DOJ clearance letter.

   Indicator:
   Percent of lump sum awards processed within 30 calendar day of receipt of a DOJ clearance letter.

E. Process payment of 90 percent of attorney fees within 30 calendar days of receipt of DOJ clearance letter.

   Indicator:
   Percent of attorney fees processed within 30 calendar days of receipt of DOJ clearance letter.

F. Make annuity payments via electronic funds transfer directly to all insurance carriers within 24 hours to meet underwriting deadlines to reduce the volume and necessity of annuity premium refunds, thus providing the opportunity to purchase annuity contracts immediately at the most favorable current rates.

Indicator:
Percent of annuity payments made via electronic funds transfer directly to insurance carriers within 24 hours.

Data Collection and Validation:

Primary data collection comes from program data through the daily tracking of required payment and legal documentation. Additional information will be obtained from submissions provided annually to the VICP from the Food and Drug Administration and from DTP manufacturers.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 Request
VICP			
Approp: Pre 10/1/88 Claims	---	---	---
Trust Fund: Post 10/1/88 Claims	$51,600	---	$51,600
HRSA Admin Costs	3,000	---	3,000

SPECIAL PROGRAMS

Annual Performance Plan: FY 1999 Budget

Program Activity: Organ Procurement and Transplantation

Description of Program Activity:

The National Organ Transplant Act, P.L. 98-507, enacted on October 19, 1984, amended Title III of the Public Health Service Act to authorize a program of grants to organ procurement organizations (OPOs) and establish a Task Force on Organ Procurement and Transplantation. The purpose of the program is to increase the number of organ donations and successful matches. (The law was later amended to include contracts as well as grants and other private non-profits entities in addition to OPOs). The law also authorized the establishment and operation of an Organ Procurement and Transplantation Network (OPTN) to match donor organs to recipients, and the establishment of a scientific registry of recipients of organ transplants to tract recipients from the time of transplant to graft failure or death.

Annual Performance Goals and Performance Indicators:

Performance Goals:

A. In FY 1999 the percentage of organs procured nationally from donors will increase by 3 percent over the previous year's totals. (In 1996 the number of donors was 5,400).

   Indicator:
   Number and percent change of organs procured nationally from donors.

B. In FY 1999 the percentage of patients receiving organ transplants will increase by 3 percent over the previous year's totals. (In 1996 the number of patients receiving organ transplants was 20,260).

   Indicator:
   Number and percent change of patients receiving organ transplants

C. In FY 1999 the percentage of minority patients receiving organ transplants will increase by 3 percent over the previous year's totals. (In 1996 the number of minority patients receiving organ transplants was 5,950.)

   Indicator:
   Number and percent change of minority patients receiving organ transplants.

D. In FY 1999 the percentage of organs procured nationally from minority donors will increase by 3 percent over the previous year's totals. (In 1996 the number of organs procured nationally from minority donors was 1,180).

Minority Objective*:

Race	1996	1997	1998	1999
African-Americans	12.1%	12.4%	12.5%	12.6%
Hispanics	9.1%	9.4%	9.5%	9.6%
Asian-Americans	2.9%	3.2%	3.3%	3.4%

*The objective is to reach the minority percentages of the U.S. population. While Hispanic organ donations have exceeded their percentage of the population, demographers estimate that by the year 2010, persons of Hispanic origin will surpass the non-Hispanic African-American population as the largest minority group (U.S. Bureau of the Census). By the year 2050, demographers project that 22.7 percent of the U.S. population will be Hispanic.

Indicator:
Number and percent change of organs procured nationally from minority donors.

E. In FY 1999, increase the number of transplant programs submitting data electronically to the OPTN and Registry to 100 percent of all transplant programs. (In May 1997, there were 891 transplant programs. About 20 percent were submitting data electronically.)

Indicator:
Number of Organ Transplant Programs; number of Organ Transplant Programs submitting data electronically to the OPTN and Registry.

F. In FY 1999, increase to 100 percent the number of Organ Transplantation programs implementing standard medical criteria for determining priority status on the waiting list of potential kidney, liver, heart, pancreas, and lung transplant patients. (In 1995, the criteria were approved for kidney, liver, heart, pancreas, and lung transplant patients.)

Indicator:
Number of Organ Transplantation programs; number of Organ Transplantation programs implementing standard medical criteria for determining priority status on the waiting list of potential kidney, liver, heart, pancreas, and lung transplant patients.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

This program is also supportive of the goals in the Department Strategic Plan. It is particularly supportive of Goal 3: Improve access to health services and ensure the integrity of the Nation’s health entitlement and safety net

programs, including Strategic Objective 3.2: Increase the availability of primary health care services, and Strategic Objective 3.2: Improve access to and the effectiveness of health care services for persons with specific needs. It is also supportive of Goal 4: Improve the quality of health care and human services, particularly Strategic Objective 4.2: Reduce disparities in the receipt of quality health care services.

Data Collection and Validation:

Data maintained under the Organ Procurement and Transplantation Network and Scientific Registry of Transplant Recipients, contracts with the United Network for Organ Sharing. 1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

Authorizing Legislation -- Sections 371-377 of the Public Health Service Act.

(Dollars in Thousands)

	FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
Network:	565	58	623
Registry:	1,493	0	1,493
Awareness:	720	1,280	2,000
Total	2,778	1,338	4,116

Annual Performance Plan: FY 1999

Program Activity: **National Bone Marrow Donor Program**

Description of Program Activity:

The National Bone Marrow Donor Program maintains a program of grants and/or contracts to qualified recipients to advance the knowledge of bone marrow transplantation and to increase bone marrow donor recruitment among targeted populations. The program initiates and manages studies which address problems relating to bone marrow donation and the matching of patients with donors. They monitor trends and analyze data on the efficiency and effectiveness of bone marrow procurement, the allocation of bone marrow among transplant centers and transplant patients and on other aspects of bone marrow transplantation. The program is responsible for policy and regulatory development in the area of bone marrow recruitment, and matching.

Annual Performance Goals and Performance Indicators:

Performance Goals:

A. In FY 1999, the percentage of unrelated patients receiving bone marrow transplants will increase by 20 percent over previous year totals. (In 1996 the number of patients receiving bone marrow transplants was 1,174.)

   Indicator:
   Number and percent change of unrelated patients receiving bone marrow transplants.

B. In FY 1999, the percentage of unrelated minority patients receiving bone marrow transplants will increase by 35 percent over previous year totals. (In 1996, there was a 37 percent increase in minority bone marrow transplants.)

   Indicator:
   Number and percent change of unrelated minority patients receiving bone marrow transplants.

C. In FY 1999, the percentage of unrelated bone marrow donors nationally will increase by 10 percent over previous year totals. (In 1996, the number of bone marrow donors was 2.58 million.)

   Indicator:
   Number and percent change of unrelated bone marrow donors nationally.

D. In FY 1999, the percentage of unrelated minority bone marrow donors will increase by 20 percent over previous year totals. (In 1996, the number of minority bone marrow donors was 200,000)

   Indicator:
   Number and percent change of unrelated minority bone marrow donors.

Link to Strategic Goals and Objectives:

The above program specific performance measures are supportive of the following HRSA Strategic Goals:

- Eliminating Health Disparities
- Eliminating Barriers to Care
- Assuring Quality

This program is also supportive of the goals in the Department Strategic Plan. It is particularly supportive of Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs, including Strategic Objective 3.2: Increase the availability of primary health care services, and Strategic Objective 3.2: Improve access to and the effectiveness of health care services for persons with specific needs. It is also supportive of Goal 4: Improve the quality of health care and human services, particularly Strategic Objective 4.2: Reduce disparities in the receipt of quality health care services.

Data Collection and Validation:

Registry data for performance goals 1-4 are obtained by the National Marrow Donor Program. 1998 Baseline data will be available in calendar year 1999 for all performance measures.

Funding Level Associated with this Program Effort:

Authorizing Legislation -- Title III of the Public Health Service Act.

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$15,270	---	$15,270

RURAL HEALTH

Annual Performance Plan: FY 1999 Budget

Overview: The charge to the Office of Rural Health Policy from Congress in 1987 was to serve as a proponent for rural interests in the Department's health care policy process. The office has a specific mandate to review HCFA proposals and regulations, to maintain an information clearing house, and provide information on rural health activities in other federal agencies.

The Office of Rural Health Policy is the only office in the department solely concerned with rural health care needs. It is active in coordinating rural health care programs and policies within HRSA, with HCFA, and with many federal agencies such as USDA, NTIA, and the FCC, and with the (White House) Joint Working Group on Telemedicine. Because the challenges to providing adequate care in rural communities are manifestations of many structural issues in the national health care 'system,' the office has become strategically involved in efforts, large and small, to bring about national reforms.

The office engages in a wide spectrum of activity -- from research and policy development to constituency-building, to demonstration grants for new rural service delivery systems. We administer five grant programs and provide approximately 250 grantees and contractors with technical assistance through workshops, phone-conferences, site visits, and other efforts. To cultivate local support for rural health issues, the office has promoted extensive networking among rural health interests within and among the states. This has resulted in a national information network. We support state and regional conferences and lend financial and technical support for new rural health initiatives.

Program Activity: Rural Health Outreach, Network Development, and Rural Outreach Pilot Programs, Technical Assistance Resource Center, and the Rural Information Health Service (RICHS)

Description of Program Activity:

Rural Health Outreach Grant Program. This program activity supports many of the service and information outreach activities of the Office. The goals of the Rural Health Outreach Grant program and the newly authorized Rural Network Development program are to improve access to health services in rural communities through the development of new models of health care services that sustain greater collaboration among providers. To date, there has been very little systematic or quality information available about either the effectiveness of emerging models for providing health services in rural areas or the development of rural-based networks in the emerging competitive markets of the 1990s. Rural Health Outreach Grants require grantees to develop and implement a consortium with at least two other providers to strengthen existing health care services or bring new services to a rural community.

The focus of these programs is on service delivery and cooperation among providers. Services paid by the grants include primary care, mental health, dental care, health education and promotion, distance learning, transportation, services to special populations (i.e. Alzheimer, diabetics, etc.), school clinics and a wide range of other activities. Target populations include the elderly, rural minorities, adolescents, Native Americans, pregnant women, children, etc. Over 350 grants have been awarded since 1991 to hospitals, public health agencies, charitable organizations, community-based providers, educational institutions, physician groups, etc. The average grant serves over 7,000 people per year. About 60 percent of grantees continue their services after federal support is ended and this percentage is improving. Grants have been made in 46 states and the territories. At least 350 applications for the program are received each year. In FY 1997, we received almost 400 applications and we made 53 new awards (plus continuation of 57 grants).

Rural Network Development Grants are designed to support the development of vertically integrated provider networks in rural communities. The program is founded on the belief that locally developed networks can improve access to care in rural areas, better coordinate local health care services, and help rural providers and communities respond to the growth of managed care. Under this program, the focus is on developing the organizational capabilities of rural networks as opposed to the actual delivery of services. Authorized by Congress in 1996, the program was announced for the first time in December, 1996. The first 34 awards were made in September, 1997. The grantees will participate in an evaluation activity that will result in program performance measures for future grantees and the program as a whole.

Outreach Pilot Initiative. The proposed Outreach Initiative would be implemented in FY 1999. It would provide up to $2 million to fund as many as 10 demonstration grants to allow rural communities to train and employ local lay citizens to provide outreach services to residents in their communities. This program builds upon our experience in isolated rural communities that has demonstrated the value of locally trained lay citizens in reaching out to hard-to-reach populations and bringing them into the health care system for preventive and primary care services. The model has been successfully used in remote Alaskan villages and in some Hispanic communities. Local residents will be given the skills needed to identify members of their communities in need of health care services and to link them with the appropriate providers. They will also provide some basic health education services consistent with their training and the needs of the communities they serve. The program will also provide training and employment opportunities for individuals making the transition from welfare to work. Thus, this program also builds upon the FY 1997 enacted Welfare Reform legislation which requires state efforts to increase employment opportunities for these populations in the health care service sector in rural areas.

A **Technical Assistance Resource Center** will be established in FY 1999 to provide technical assistance to ORHP and other HRSA rural grantees attempting to develop integrated rural health care systems. The needs of current ORHP grantees, rural communities, and states for ongoing technical assistance far exceed the current capacity of the Office to provide it. At a minimum, an

appropriate level of effective technical assistance is essential for protecting the Federal investment in these grantees, and to enhance their current performance and future sustainability when Federal support ends. The Technical Assistance Resource Center will provide assistance on community health data, network development and related activities as identified through a variety of mechanisms including identification by grantees in ORHP's network development program, state offices of rural health and other informed sources. Over time, the broader needs of rural communities and states also would be addressed by the Center. The Resource Center will be located in a non-profit institution and be financially self-sustaining after 3 years through fees paid by grantees and private parties.

The Rural Information Center Health Service (RICHS) enhances the federal government's ability assist rural residents in obtaining the information they need to address their personal health care problems and those in their communities. RICHS provides customized assistance to individuals seeking rural health information, searches of data bases on requested topics, and directs callers to organizations and experts in the field who provide additional information. RICHS also provides a variety of publications on frequently requested topics, such as those on federal funding sources for rural health services or rural managed care.

Annual Performance Goals and Performance Indicators:

Performance Goals

A. **Rural Health Outreach Grant Program**: To develop and operate collaborative models of rural health services delivery, provide funding to 16 new and 69 ongoing projects serving 595,000 persons. [Baseline: 95 [projects serving 665,000 persons]

   Indicator:
   Number of persons served and number of grantees

B. **Rural Network Development Program**: To improve rural health care access by developing vertically integrated provider networks, provide funding for 10 new and 44 continuing grantees to assist 270 rural providers to coordinate their delivery of health services. [Baseline: 44 grants)

   Indicators:
   - Number of providers engaged in formation of vertically integrated provider networks
   - Number of network projects supported

C. **Outreach Pilot Initiative**: Increase by 70,000 the number of people reached by outreach health services in rural communities by funding 10 lay health worker outreach grants to train and employ 40-100 lay citizens. [Baseline: 0 grants]

   Indicators:
   - Number of lay health workers trained and employed as health care workers
   - Number of persons receiving outreach health services.

D. **Establish Technical Assistance Resource Center**: Improve service to rural communities by establishing and implementing a centralized resource for technical assistance to 10-20 rural communities developing integrated rural health care systems. [Baseline: 0 communities served]

Indicator:
Number of communities served in first year.

Link to Strategic Goals and Objectives:
This group of Rural Health programs is supportive of the following HRSA Strategic Goals:

- Eliminating Barriers to Care
- Eliminating Health Disparities
- Assuring Quality of Care

These programs are also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs, objective 3.2: Increase availability of primary health care services.

Data Collection and Validation:

A. **Outreach**: It is planned to develop a standardized reporting system to collect and analyze data from grantees to be used by HRSA to systematically evaluate the performance of grantees. Baseline data will be collected in FY 1998 to establish target indicator values and improvements in performance indicators will be measured in FY 1999. One challenge to the design of a meaningful standardized data system for this program is the wide range of projects funded, reflecting widely diverse objectives, activities, and populations served.

B. **Network Development:** The new Rural Network Development grantees will be required to submit a standard report at least once a year in addition to their noncompeting grant application. The report form has been approved by the Office of Management and Budget. The data will be used for overall program evaluation and to establish performance measures for the first grantees and subsequent participants in the program. An independent evaluator has been selected to review and analyze the data.

C. **Outreach Pilot Initiative**: Grantee annual reports

D. **Resource Center:** An evaluation instrument for the Technical Assistance Resource Center will be developed to assess the effectiveness of the program. The grantee will be required to submit a standard report at least once a year as a part of its noncompeting grant application. To the extent possible, data for this report should be available from routine records to be maintained by the Center.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
$32,592	---	$32,592

Annual Performance Plan: FY 1999 Budget

Program Activity: Rural Health Policy Development

Description of Program Activity:
This program activity represents a cluster of programs that support the policy development functions of the Office of Rural Health Policy. They are designed to help policy-makers, both in Washington and throughout the nation, better understand the impact of changes in both the governmental and private sectors on rural communities.

The Rural Health Research Center Program is the only health services research program dedicated entirely to producing rural policy relevant research. It currently supports five research centers that have over 50 major studies underway dealing with such diverse topics as the impact of Medicare Graduate Medical Education (GME) subsidies on rural hospitals to the rural workforce implications of National Practice Guidelines.

Rural Telemedicine Grant Program. This budget line also funds ORHP's Rural Telemedicine Grant Program, a program designed to elucidate the role of telemedicine in overcoming the isolation of rural practitioners, improving the health services available to rural residents, and supporting the growth of integrated health care delivery systems in rural communities. Funds will be used to provide continued support for 19 grants that will be in their third year.

In addition to the above activities, this request would continue support for: (1) the National Advisory Committee on Rural Health which advises the Secretary on the effects of changes in Federal policies on rural communities and serves as an important link to the rural constituency groups; (2) staff support to the Joint Working Group on Telemedicine, a Federal interagency body which coordinates telemedicine policy across government agencies; and (3) small special projects (generally under $25,000) that assist the Office in identifying and clarifying rural health issues.

Annual Performance Goals and Performance Indicators

Performance Goals:

A. **Rural Research Center Grant program:** Sustain the production of rural health policy relevant research by providing funds to 5 grantees to complete 3 to 5 projects each in FY 1999. [Baseline: 5 grants; average of 3 completed projects per year.]

   Indicator:
   Number of completed research projects

B. **Rural Telemedicine Grant Program**: Improve access to primary care and specialty health services and increase retention of providers through continued funding and evaluation of 18 current grants.
   [Baseline: 19 grants; baseline for number of persons served in home community, number of services available locally through telemedicine, and number of providers available through telemedicine to be established]

Indicators:

- Number of services available locally through telemedicine
- Number of providers available through telemedicine
- Number of persons served

Link to Strategic Goals and Objectives:

This group of Rural Health programs is supportive to the following HRSA Strategic Goals:

- Eliminating Barriers to Care
- Eliminating Health Disparities
- Assuring Quality of Care

These programs are also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs, and objective 6.4: Increase the understanding of and response to the major issues related to the quality, financing, cost, and cost-effectiveness of health care services.

Data Collection and Validation:

A. Number of completed projects submitted to granting office and reported in grantee year-end reports and/or non-competing continuation applications.

B. For the telemedicine programs, it is planned for FY 1998 and 1999 to establish more refined mechanisms of evaluation including improvements in routine reporting systems. All grantees must submit annual reports. A set of routine reporting forms have been developed for grantees to permit evaluation across grantee programs.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	* FY 1999 President's Budget
$11,713	---	$11,713

Annual Performance Plan: FY 1999 Budget

Program Activity: **State Offices of Rural Health Grant Program**

Description of Program Activity: This program activity supports a focal point for rural health in every state. Matching grants provide for an innovative federal and state partnership that helps communities address their problems while also keeping national policy makers aware of what is needed. Each SORH is responsible for three key activities to help meet state needs:

1) collect and disseminate information,
2) coordinate resources and activities statewide and
3) provide technical and other assistance.

Since the start of this program in 1991, the number of state offices has increased from 7 to 50.

Annual Performance Goals and Performance Indicators:

Performance Goal:
Increase the number of states with full-service programs of information, coordination and technical assistance, so as to strengthen their ability to identify needs and improve access to health care for their rural communities.

Indicator: Number of states with full-service programs of information, coordination and technical assistance.

Link to Strategic Goals and Objectives:
This activity is supportive of HRSA strategic goals:

- Eliminating Barriers to Care
- Eliminating Health Disparities

It is also supportive of the Department Strategic Plan, particularly Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs.

Data Collection and Validation:
A. Effectiveness: During FY 1999, a standardized reporting system will be established that will allow ORHP to systematically evaluate and improve the performance of grantees. Performance measures will include the number of states 1) publishing a newsletter, 2) sponsoring an annual statewide meeting, and 3) providing technical assistance.

Funding Levels Associated with this Program Effort:

(Dollars in Thousands)

FY 1998 Appropriation	FY 1999 Increment	FY 1999 President's Budget
($3,000)	---	($3,000)

(Funding allocated from National Health Service Corps Recruitment line.)